Maternal and Child Health Services
Title V Block Grant

State Narrative for New Jersey

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are available and maintained on file in the Office of the Assistant Commissioner of the Division of Family Health Services.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

/2009/ To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing was held on May 20, 2008. A draft of the application narrative was posted on the Department's website four weeks prior to the public hearing. Notice of the public hearing was published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was be mailed to over 300 individuals on the Division of Family Health Services mailing list. Testimony was presented by five individuals.

Lauren Agoratus, a parent and NJ Coordinator for Family Voices at the Statewide Parent Advocacy Network, presented testimony supporting programs developed with MCH Block Grant funds for children with special health care needs (CSHCN) and voiced concern with the proposal of the Regional Early Intervention Collaboratives to be the single point of entry into early intervention. Marilyn Cohen from the NJ Federation of Cleft-Craniofacial Centers provided testimony supporting the MCH Block Grant in the areas of transitioning CSHCN to adulthood and oral health, and raised the issues of underinsurance and inadequate reimbursement for the management of clefts and craniofacial conditions. Susan Freedman, a county case manager for Special Child Health Services, and Kelly Hartigan, a parent, provided support for the county based case management system for CSHCN and called for additional funding support. Linda Doherty, the President of the NJ Food Council, voiced concern for the new WIC regulations and asked for flexibility in planning for their implementation.

The draft of the application narrative posted on the Department's website received over 950 viewer hits between April and June of 2008.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E //2009//.

/2010/ To include public input into the annual development of the MCH Block Grant Application and Annual Report, a public hearing was scheduled for May 19, 2009. A draft of the application narrative was posted on the Department's website four weeks prior to

the public hearing. Notice of the public hearing was published in local newspapers throughout the State. Notification of the public hearing and availability of the draft application on the Department's website was mailed to over 300 individuals on the Division of Family Health Services mailing and e-mail lists. Although only two individuals signed up to present verbal testimony and the public hearing was cancelled, nine written letters of support were received.

Input into Title V activities is encouraged throughout the year through involvement of individuals and families in the many advisory groups and task forces as described in Section III.E //2010//.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The Needs Assessment must be submitted every five years. The last Needs Assessment was submitted in 2005, with the 2006 application and the 2004 annual report.

There have not been any significant changes to the Needs Assessment process that would require an update to the previously submitted Needs Assessment.

Attached is a brief seven page summary and overview of the Needs Assessment process.
An attachment is included in this section.

III. State Overview

A. Overview

/2010/ The Maternal and Child Health block grant application and annual report, submitted annually by all states to the Maternal Child Health Bureau (MCHB), contains a wealth of information concerning State initiatives, State-supported programs, and other State-based responses designed to address their maternal and child health (MCH) needs. The Division of Family Health Services (FHS) in the New Jersey Department of Health and Senior Services (NJDHSS), Public Health Services Branch posts a draft of the MCH Block Grant application and annual report narrative to its website to receive feedback from the maternal and child health community.

A brief overview of New Jersey demographics is included to provide a background for the maternal and child health needs of the State. While New Jersey is the most urbanized and densely populated state with 8.7 million residents, it has no single very large city. Only six municipalities have more than 100,000 residents.

Compared to the nation as a whole, New Jersey is more racially and ethnically diverse. According to the 2007 New Jersey Population Estimates, 76.3% of the population was white, 14.5% was black, 7.5% was Asian, 0.3% was American Indian and Alaska Native, and 1.3% reported two or more races. In terms of ethnicity, 15.9% of the population was Hispanic. The racial and ethnic mix for New Jersey mothers, infants, and children is more diverse than the overall population composition. In 2007, 26.4% of mothers delivering infants in New Jersey were Hispanic, 47.0% were white non-Hispanic, 15.3% were black non-Hispanic, and 9.6% were Asian or Pacific Islanders non-Hispanic. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Maternal and child health priorities continue to be a focus for the NJDHSS. The Division of FHS, the Title V agency in New Jersey, has identified improving access to health services with a focus on early prenatal care, reducing disparities in health outcomes and increasing cultural competency of services as three priority goals for the MCH population. Specific attention has been placed on the reduction of racial and ethnic disparities in early access to prenatal care, black infant mortality, preterm births, childhood lead poisoning, obesity prevention, asthma prevention, newborn biochemical screening, reduction of risk taking behaviors among adolescents, and women's health.

In order to improve New Jersey's commitment to maternal and child health, Commissioner Heather Howard accepted a report from the Prenatal Care Task Force in August 2008. The recommendations in the report focused on four major areas 1) Education; 2) Access to Reproductive Health Care Services and Practitioners; 3) Systems and 4) Evaluation. The recommendations stress many important goals such as increasing public awareness of preconception health; ensuring the availability of ongoing early prenatal care services for women in areas affected by hospital closures and or reduction in obstetric services and promoting equity in birth outcomes. The Task Force Report is now being used as the blueprint for many of the Title V activities in perinatal health.
Commissioner Howard has embarked on a public and professional awareness campaign to promote the need for women to receive early prenatal care and to have a healthy pregnancy and birth. The campaign is "A Healthy You = A Healthy Baby". The Commissioner has visited WIC clinics in Newark and Camden; health centers in Jersey City, Asbury Park, and Irvington; a Trenton Community Baby Shower; and met with college students. She spoke with women about how their actions today can affect the health and well-being of future children, and the importance of maintaining a healthy lifestyle before they get pregnant, during pregnancy and in between pregnancies.

To improve access to health services, the State has provided reimbursement for uninsured primary medical and dental health encounters through the designated Federally Qualified Health Centers (FQHCs) since 1992. In SFY 2009, $5 million in state funding was again appropriated to enhance capacity of the health centers to increase primary care for underserved populations. This year there was a special focus on increasing access to prenatal care and to address the need for primary care health services in areas impacted by the closure of a hospital. In SFY 2010, reimbursement for uninsured care is expected to remain at $40 million.

Title V services within FHS will continue to support enabling services, population-based preventive services, and infrastructure services to meet the health of all New Jersey's families. Title V will continue to maintain a safety net of services, especially for children with special health care needs. Even with reduced financial barriers to health care for children, challenges persist in promoting access to services, reducing racial and ethnic disparities, and improving cultural competency of health care providers and culturally appropriate services.

The Newborn Biochemical Screening Program currently screens every baby born in New Jersey for twenty disorders. An expansion of the newborn screening panel to 54 disorders was completed in April 2009.

According to the Centers for Disease Control and Prevention's (CDC) most recent prevalence figures released through its Morbidity and Mortality Weekly Report (MMWR) of February 7, 2007, one of every 94 children in New Jersey has autism, which is the highest rate among the states examined by the CDC in the most comprehensive study of the prevalence of autism to date.

During this past year, many of the Legislated initiatives administered by DHSS to address the needs of children and families affected by autism and autism spectrum disorders are now in place.

•The Governor's Council for Medical Research and Treatment of Autism (the Council) has been integrated into the Division of Family Health Services at DHSS. Grants to enhance clinical services have been awarded and a new Request for Proposals in the area of research has been issued.

•The State's proposed rule for the implementation of the Autism Registry was published and is expected to be adopted by July 2009. The registry will include a record of all reported cases of autism with other information deemed relevant and appropriate to (a) improve current knowledge and understanding of autism, (b) conduct thorough and complete epidemiologic surveys of autism, (c) enable analysis of this problem and (d) plan for and provide services to children with autism and their families.

•The Department released the Early Identification of Autism Spectrum Disorders: Guidelines for Healthcare Professionals in New Jersey in April 2009. The guidelines for health care professionals will assist in evaluating infants and toddlers living in the State for autism to ensure timely referral to appropriate services as well as dissemination of information on the medical care of persons with autism to health care professionals and the general public.

Both nationally and in New Jersey, obesity is a growing epidemic. The New Jersey Council on Physical Fitness and Sports, created under Public Law 1999 Chapter 265, will hold its 3rd Annual Leaders' Academy for Healthy Community Development conference in the fall of 2009. Again, mini-grants of $2,500-$10,000 will be awarded through a

competitive grant process, to community based agencies/organizations (CBO's) to address the obesity problem within their community.

In May, 2008 the Department of Health and Senior Services was one of 23 states awarded a 5 year cooperative agreement (July 2008 - June 2013) by the Centers for Disease Control and Prevention (CDC) to the ONF to provide state leadership and coordination of nutrition, physical activity and obesity strategies (NPAO). Through this cooperative agreement, DHSS will collaborate with the existing infrastructure, the Mobilizing for Action through Planning and Partnerships (MAPP) framework and their county level NPAO workgroups to create a comprehensive and coordinated system needed to halt further increases in obesity and other chronic diseases. NPAO is recognized as the #2 statewide public health priority based on a summary of the NJ Community Health Improvement Plans (CHIPs).

Simultaneously, a 5 year cooperative agreement was awarded by the CDC to the Department of Education (DOE) to collaborate with the DHSS on a Coordinated School Health Program to address nutrition, physical activity and tobacco.

Finally, this year the activities of the Office on Women's Health (OWH), in the DHSS, have been suspended. This was the direct result of the state's fiscal crisis and hiring freeze. Peri Nearon, director of the Office of Women's Health, has been reassigned as the director, of the Office of Nutrition and Fitness. Although the OWH successfully implemented many programs over the past five years, there were not adequate resources to maintain the OWH. //2010//
An attachment is included in this section.

B. Agency Capacity

The mission of the Division of Family Health Services (FHS) is to improve the health, safety, and well being of families and communities in New Jersey. The Division works to promote and protect the health of mothers, children, adolescents, and at-risk populations, and to reduce disparities in health outcomes by ensuring access to quality comprehensive care. Our ultimate goals are to enhance the quality of life for each person, family, and community, and to make an investment in the health of future generations.

The statutory basis for maternal and child health services in New Jersey originates from the statute passed in 1936 (L.1936, c.62, #1, p.157) authorizing the Department of Health to receive Title V funds for its existing maternal and child services. When the State constitution and statutes were revised in 1947, maternal and child health services were incorporated under the basic functions of the Department under Title 26:1A-37, which states that the Department shall "Administer and supervise a program of maternal and child health services, encourage and aid in coordinating local programs concerning maternal and infant hygiene, and aid in coordination of local programs concerning prenatal, and postnatal care, and may when requested by a local board of education, supervise the work of school nurses."

Other statutes exist to provide regulatory authority for Title V related services such as: services for children with Sickle Cell Anemia (N.J.S.A. 9:14B); the Newborn Screening Program services (N.J.S.A. 26:2-110, 26:2-111 and 26:2-111.1); genetic testing, counseling and treatment services (N.J.S.A. 26:5B-1 et. seq.,); services for children with hemophilia (N.J.S.A. 26:2-90); the birth defects registry (N.J.S.A. 26:8-40.2); the Catastrophic Illness in Children Relief Fund (P.L. 1987, C370); the childhood lead poisoning prevention program (Title 26:2-130-137); and the SIDS Resource Center (Title 26:5d1-4). Recent updates to Title V related statutes are mentioned in their relevant sections.

The following is a description of New Jersey's Title V capacity to provide preventive and primary care services for pregnant women, mothers and infants, preventive and primary care services for children, and services for CSHCN.

III. B. 1. Preventive and Primary Care for Pregnant Women, Mothers and Infants

The mission of Maternal, Child and Community Health Service (MCCH) within FHS is to improve the health status of New Jersey families, infants, children and adolescents in a culturally competent manner, with an emphasis on low income and special populations. Reproductive and Perinatal Health Services, within MCCH, coordinates a regionalized system of care of mothers and children through the six Maternal and Child Health Consortia (MCHC). The MCHC were developed to promote the delivery of the highest quality of care to all pregnant women and newborns, to maximize utilization of highly trained perinatal personnel and intensive care facilities, and to promote a coordinated and cooperative prevention-oriented approach to perinatal services. Continuous quality improvement activities are coordinated on the regional level by the MCHC.

The eight funded Healthy Mothers, Healthy Babies (HM,HB) Coalitions continue to reduce infant morbidity and mortality through outreach and education. The HM,HB Coalitions act as the Community Action Teams for the Fetal Infant Mortality Review (FIMR) project.

In the Central New Jersey Maternal and Child Health Consortia (MCHC) through the Fetal and Infant Mortality Review (FIMR) maternal interviews, gaps in maternal services as well as knowledge of such issues as fetal movement were identified. The Central New Jersey MCHC is currently in the process of launching the "Have You Felt Your Baby Move Today" campaign. This initiative involves providers as well as consumer components. Additionally, the "My Prenatal Care Card" Initiative has been launched region wide.

The Regional Perinatal Consortium of Monmouth and Ocean's FIMR Case Review Team also found "lack of fetal movement awareness" and lack of maternal action an educational issue. The action plan included creating and mass distributing bookmark-sized education tools entitled "Did Your Baby Kick Today?" to all OB practices and prenatal clinics in the area.

The HM,HB Coalitions all provide formal and informal outreach worker training. Training topics include: preconception and interconception health immunizations, personal safety, lead screening, domestic violence, child growth and development, dental health, AIDS, asthma, smoking cessation, BIMR, cultural competency, home safety, car safety, fatherhood, STI, nutrition, breastfeeding, postpartum depression, mental health, stress reduction, addictions, parenting and other topics identified by the outreach workers.

Outreach activities range from door to door canvassing to large community events. The HM,HB Coalitions sponsor community events such as Baby Showers, Baby Safety Showers, "Pregnant Pause" and Health Fairs; school- based events such as the "Game of Life", and Teen Awareness Days, and presentations for community groups and faith-based initiatives. Outreach efforts are also conducted wherever women gather such as grocery stores, hair and nail salons, laundromats and clinics.

HM,HB Coalition activities include the hiring of multicultural, multilingual staff and the recognition of changes in existing client bases. The Trenton Coalition has seen an increase in the Eastern European population, the Paterson Coalition an increase in the Middle Eastern population and the Jersey City Coalition an increase in the Hispanic population. Religious affiliations are also changing with increases in the Muslim and Hindu populations. In addition to cultural changes the family unit is also changing - increased single-father households, increased multiple births, increased adolescent pregnancies and an increase in grandparents raising grandchildren. The Coalitions are responding by increasing Coalition membership from these groups. Professional and consumer education is also being expanded to include the unique needs of the population. The HM,HB Coalition of Jersey City awarded a subgrant to a community-based organization that demonstrated the capability to provide grassroots outreach and education that link vulnerable

populations to community-based health care services. The Coalition is currently funding the Women Reaching Women program. This initiative targets African American women in the neighborhoods that have been identified as having the highest risk of poor birth outcomes. Through intensive outreach efforts, the Women Reaching Women program brings pregnant women into early prenatal care and through education the program promotes prevention and positive health choices. The program conducts comprehensive sexuality education in middle and high schools and provides cultural competence training for health care providers and community-based agencies.

/2010/ The Prenatal Care Task Force Report included a recommendation to re-evaluate priority areas for infant mortality reduction funding and then redirect those funds as appropriate. A Request for Proposals is in process for release in the spring. //2010//

Perinatal Addiction Prevention Services are also part of the Reproductive and Perinatal Health Services Program. Professional, public and patient education is offered regarding the effects of using alcohol, drugs and tobacco during pregnancy. Prenatal providers are encouraged to use a standardized screening tool with their patients.

III. B. 2. Preventive and Primary Care for Children and Adolescents

The Child and Adolescent Health Program, within MCCH, focuses on primary prevention strategies. Adolescent Health funds the Community Partnership for Healthy Adolescents initiative and addresses injury and violence (including bullying and gangs), risk behavior reduction through positive youth development approaches, and school health. In Child Health, special emphasis has been placed on outreach and education of health care providers and the public, to ensure the screening of children under six years of age for lead poisoning.

The Childhood Lead Poisoning Prevention (CLPP) Project is a home visiting program providing outreach and case management for children six years of age or younger. Thirteen sites throughout the State receive funding to assess blood lead levels, immunization status, nutritional status, growth and developmental milestones, and parental-child interaction and then provide education, supportive guidance, and referral as required.

The goal of the CLPP Project is to promote a coordinated support system for lead burdened children and their families through the development of stronger linkages with Medicaid HMOs, DYFS, community partnerships, Special Child Health Services, the Department of Education, Department of Community Affairs, and other community agencies providing early childhood services. Only through a coordinated effort by all of these entities will the intensive case management needs of these families be addressed and preventive health strategies initiated.

Promoting healthy and safe early childhood programs has also been on the State's agenda. In September 2005, New Jersey was one of 18 states that were awarded an Early Childhood Comprehensive Systems (ECCS) implementation grant. The ECCS Team continues to work with a myriad of public and private agencies, including the Build NJ -- Partners for Early Learning and the Department of Human Services, Office of Children's Services that are charged with two other grant supported projects with similar and complementary goals. A priority of the ECCS Plan for 2007 is to launch a website as a resource for parents and caregivers. The website will include topical issues reflecting the five ECCS components -- access to care, social and emotional development, early care and education, parent education, and family support.

As a project with the Healthy Child Care New Jersey (HCCNJ) grant, a PLAY (Physical Lifestyles for Active Youngsters) Task Force was established in 2003 on the recommendation of the participants of the HCCNJ Advisory Board. The PLAY Task Force has now joined with the Interagency Council on Osteoporosis (IOC) to combine its efforts: 1) to promote physical activity in young children from birth to five and 2) to include early childhood nutrition principles and

practices to develop lifetime habits for healthy eating. The work of the expanded PLAY Task Force includes the development of a preschool nutrition curriculum for children three to five years of age and was piloted at the 16th Annual Health in Child Care Conference on May 30, 2007. Ninety participates attended two workshop sessions. The Task Force will also be making recommendations to the Department of Children and Families, Office of Licensing to strengthen nutrition and physical activity regulations for children in licensed child care centers and registered family child care homes.

Systems building partnerships have expanded to include the newly established Department of Children and Families, Division of Prevention and Community Partnerships, the Head Start-State Collaboration Project and the Governor's Office. New Jersey was one of three states awarded the National Governor's Association Grant entitled "Supporting Gubernatorial Leadership for Building Early Childhood Systems". This grant will oversee coordination efforts across state agencies that work on early care and education initiatives with a particular emphasis on funding and data issues.

Child Care Health Consultant Coordinators (CCHCCs) are located in the county resource and referral agencies statewide and are supported by Child Care Development Block Grant funds. In addition to providing on-site consultation, a broad range of health and safety topics are provided to child care providers, parents and children.

The Children's Oral Health Education Program provides a variety of age appropriate educational activities to school age children through support of regional programs. The voluntary weekly fluoride mouth rinse program, "Save Our Smiles" is targeted towards high risk children in areas that do not have optimally fluoridated water.

III. B. 3. Preventive and Primary Care for Children with Special Health Care Needs

Special Child Health and Early Intervention Services (SCHEIS) ensures that all persons with special health needs have access to comprehensive, community-based, culturally competent and family-centered care. A priority for SCHEIS is ensuring rehabilitative services for blind and disabled individuals less than 16 years old receiving services under Title XIX. SCHEIS receives monthly printouts from the Social Security Disability Determination Unit that identify all children recently determined eligible for Social Security Insurance (SSI). Copies of the printouts are sent to the appropriate County Case Management Units. County Case Management Units outreach to all SSI applicants to offer information, referral, and case management services.
/2007/ This process is targeted for update in 2007 to improve transmission and management of data as well as follow-up and monitoring. Electronic transmission of SSI data from the State office to the County Case Management Units will be explored and piloted.//2007//
/2008/ Following input from the SCHS County Case Managers, the monthly SSI print-out format was revised into two reports: unduplicated live new referrals by month with an annual end-of-year cumulative report; and terminated children only. The intent of these revisions was to streamline the volume of data for improved ease in follow-up and improve control for duplicate referrals. State staff participated in an Office of Information Technology demonstration of the State Portal as a potential method for the County Case Managers to gain electronic access to the SSI print-out. Input from the end-users is being explored to determine needed hardware, training and cost for future implementation.//2008//
/2009/ Revisions to the SSI print-out and the ability to use the State portal for access to an electronic report remain priorities.//2009//
/2010/ Access to the State portal for SSI printouts continues to remain a priority. Telephone numbers of families, when possible have been added to the SSI printout, this allows the Case Managers faster and more direct access to families.//2010//

In addition, Individual Service Plans that address the medical, dental, developmental, rehabilitative, social, emotional, and economic needs of the child and/or family are developed.

Periodic monitoring of needs and progress toward attaining services are also conducted.
/2007/ The Case Management monitoring tool currently used by State staff to evaluate development of Individualized Service Plans, compliance with SSI printout, reporting of linkage with medical home, and transition to adulthood is being revised and will be piloted in 2007. //200/7//
/2008/ The revised monitoring tool was used by State staff during site visits conducted twice a year and enabled staff to more closely target grantees' strengths, areas of improvement and need for technical assistance in a concise format. State staff is exploring further uses of the tool, including the development of a monitoring database.//2008//
/2010/ The monitoring tool continues to be used during site visits to determine areas of strength and areas that require improvement and the need for technical assistance. The monitoring tool has been shortened to help in focusing on individualized service plan development and contacts with families. Site visits are being done on a priority basis. //2010//

/2007/ Maternal and Child Health Block grant funds were used in 2006 to support two significant initiatives intended to better provide transition to adulthood services for children and youth with special health care needs. Funding was allocated to support a collaborative effort with the Statewide Parent Advocacy Network for development of a New Jersey specific transition to adulthood tool intended for use by families of CSHCN and providers. This effort is slated for continuation in 2007, through a Letter of Agreement proposed by the DHSS and the New Jersey Council on Developmental Disabilities. In addition, funding also has been allocated to support a Memorandum of Agreement with Rutgers University to conduct a transition to adulthood needs assessment. This transition to adulthood activity is targeted for completion in 2006 and will include an analysis of State and Local Area Integrated Telephone Survey (SLAITS) data, interviews with 48 families of CSHCN, and interviews of pediatric and adult providers.//2007//

/2008/ The New Jersey specific Roadmap to Transition CD was developed and is being distributed statewide, including plans to post to SPAN and the Department's websites. Updates to the CD will continue as funding allows. Champions for Progress is exploring posting the CD on its website as an example of State interagency collaboration. //2008//
/2008/ A transition to adulthood needs assessment was conducted by Rutgers University which included a New Jersey specific analysis of 2000-2002 SLAIT data, pediatric specialist and adult medical provider interviews and interviews of families of children with special needs aged 16-26 years with one of the following diagnoses: Cleft Palate, Spina Bifida, Diabetes or Sickle Cell. The needs assessment was intended to determine a better understanding of the factors and issues that facilitated successful transitions as well as those barriers which prohibit the transition process. Although the sample sizes were small, the findings suggested several resources that may be helpful in facilitating transition, including family supports in the form of educational resources, workshops and tools such as lists of providers. These families would also benefit from more assistance from social service providers about their specific adult services and involvement of their pediatricians and adult doctors throughout the transition process. Physicians would also benefit from more assistance from specific providers and information on special needs, such as having a case manager to help adolescents moving toward adulthood, parent support resources and creating a "transition time." //2008//
//2009// The 21 Special Child Health Services Case Management Units continue to distribute resources to families of children with special health needs, including information from the Roadmap to Transition. This computer disk (CD) was developed through a collaborative agreement with the Statewide Parent Advocacy Network, Inc. (SPAN). SPAN likewise distributes fact sheets excerpted from the CD to pediatrician's offices where they are made available to parents or reviewed by the health practitioners in preparation for a doctor visit. //2009//
/2010/ The 21 Special Child Health Services Case Management Units continue to distribute the Road Map to Transition CD's along with county specific resources to families of children with special health care needs. They are also directing families to the SPAN website as the CD is posted to their website and is updated on a regular basis.

Elizabeth Collins, Coordinator, Specialized Pediatric Services represents the Assistant Commissioner's Office on the State Special Education Advisory Council as a Resource Representative. She collaborates with the Council's Transition Committee and provides input on medical resources as well as the teaching of social skills in preparation for career, education and life skills. The committee has been reviewing the New Jersey's Core Curriculum Content Standards and how to incorporate the necessary skills into the standards including the need for a medical home for the transitioning youth. //2010//

Although not directly supported by Title V funds, a statewide family service network providing comprehensive medical and social services to women, infants, children and adolescents for children and their families affected by HIV are also administered within SCHEIS. Through Robert Wood Johnson Medical School, the Network employs a Community Liaison to publicize the Network, provide education related to HIV disease management for consumers and providers, and provide linkages for clients to ancillary services. This network consisting of seven sites has enabled service to over 4,200 clients in 2004.
/2007/ Access to clinical trials remained a priority for Ryan White Part D clients, and the Network facilitated enrollment of 69 children, 73 adolescents, 49 adult women and 19 adult males, 2,341 patients received clinical trial education.//2007//
/2008/ Access to clinical trials remained a priority for RWTIV clients, and the network facilitated enrollment of 71 children, 115 adolescents and adult women and 8 men. //2008//
/2010/ Although the number of available clinical trials has declined over the past several years, education about and access to research is still a Part D priority, the Network facilitated enrollment of 67 children, 109 adolescents and adult women and 2 men. //2010//

SCHEIS works with parent groups, specialty providers and a statewide network of case managers to provide family-centered, community-based, coordinated care for Children with Special Health Care Needs (CSHCN) and facilitate the development of community-based services for such children and their families. The Statewide Parent Advocacy Network (SPAN) funded through SCHEIS provides parent support through a three-pronged approach titled Family WRAP (Wisdom, Resources, Advocacy and Parent-to-Parent). Specific Family WRAP programs include Project Care, Parent-to-Parent and Family Voices New Jersey.

SCHEIS attended the Champions for Progress Meeting in April of 2004. The meeting was sponsored by HRSA and the University of Utah. The purpose of the meeting was to gather information on how Title V agencies across the varied states work cooperatively with their Medicaid counter parts and their parent networks. The meeting was attended by a resource parent from SPAN and a representative from Medicaid Managed Care, as well as a nurse consultant from SCHEIS. An opportunity was offered to apply for a project grant. SCHEIS case management offered technical assistance to SPAN to apply for this stipend. SPAN has received the grant and will use the monies to enhance adolescent children's transition to adulthood. Representatives from SCHEIS Case Management and Specialized Pediatric Services participate on the SPAN Champions Center Incentive Award titled Transition from Youth to Adult Services within a Culturally Competent Medical Home for Youth with Disabilities or Special Health Care Needs, providing technical assistance and support, and liaison between the Champions and MCH Block activities.
/2007/ In August 2005, SCHEIS and SPAN attended the national Champions for Progress Meeting in Utah, presenting a poster-board overview of their collaboration on transition to adulthood activities, including the statewide Transition Roadmap Advisory Committee activities. The focus of the Transition Roadmap Advisory Committee is to address the healthcare disparities surrounding children and adolescents with special health care needs in accessing their transition to adult services. An interactive CD Roadmap is being developed to assist adolescents, families and professionals to know about the availability of services in New Jersey.//2007//
/2008/ Using a combination of financial support from the Champions for Progress initiative, Title V, and in-kind support from students and teachers at the Academies at Englewood the New Jersey specific Transition Roadmap was completed. This New Jersey specific tool was widely

distributed statewide for use by youth, parents and professionals in planning and implementing transition to adulthood.//2008//
/2009/ The Roadmap to Transition CD has been revised and updated. It serves as a resource to youth with special health care needs and their parents through the Case Management Units.//2009//
/2010/ Family Centered Care Services, Special Child Health Services Case Management nominated Mercedes Rosa, an employee of SPAN and a parent of a child with special needs to receive a Family Scholarship to attend the 2009, Association of Maternal Child Health Programs (AMCHP) meeting as a member of the New Jersey Team. Ms. Rosa participated at the meeting, providing input into parents as partners in planning for children with special health care needs. //2010//

An additional collaboration targeting improving access to specialty care and coordination with primary care for new and current patients with Epilepsy was launched in 2005. SCHEIS supported the Epilepsy Foundation of NJ, Inc.'s application to HRSA, and funding was obtained to collaborate with community based specialty providers, including Jersey Shore University Medical Center. In 2005, SCHEIS served on the statewide learning collaborative to explore community based health care needs for children with epilepsy.
/2008/ SCHEIS continued to participate with the statewide learning collaborative. This collaborative effort yielded a Toolkit for parents and physicians that included information and resources related to seizure disorders.//2008//
/2010/ The Child Evaluation Center at Jersey Shore Medical Center was a participant in the development of the Toolkit. They continue to see children and families and maintain pediatric neurologists on staff who specialize in the treatment of epilepsy. The Toolkits are available for each of the 11 CEC's in the statewide network, Pediatric Tertiary and Cleft centers through the Epilepsy Foundation. //2010//

/2008/ SCHEIS Birth Defects Registry and Family Centered Care Services staff were invited to participate on an E-MCH Webcast: Birth Defects and Developmental Disabilities Prevention: State and Local Collaborative Efforts. Sponsored by the National Association of County and City Health Officials (NACCHO) and CityMatCH the broadcast provided a forum by which New Jersey shared its system of early identification, care coordination and State and local health department collaboration in serving CSHCN.//2008//
/2009/ State SCHEIS staff presented resources and supports for families with children with special health needs during the SPAN, Inc. sponsored Lunchtime Teleconference Health Advocacy Series. This collaborative presentation reached nearly 100 parents and providers statewide. //2009//
/2010/ State SCHEIS staff collaborated on SPAN's Lunchtime Teleconference-Webinar Health Advocacy Series providing information and support. These resources are uploaded to SPAN's website. Nearly 100 parents and providers statewide participated on this teleconference. //2010//

Project Care, in existence since 1986, provides statewide family support by fourteen paid parents of CSHCN housed in 10 County Case Management Units. In addition, financial support through Project Care partially subsidized the annual SPAN conference for CSHCN.
/2007/ This process is targeted for update in 2007 to improve transmission and management of data as well as follow-up and monitoring. Electronic transmission of SSI data from the State office to the County Case Management Units will be explored and piloted.//2007//
/2008/ SPAN and SCHEIS have continued to collaborate to identify resources to expand the number of Resources Specialists (trained support specialists) on site at the SCHS Case Management Units particularly in the southern New Jersey counties. This effort remained pending. On average, statewide the Resource Specialists reported individual parent and professional contacts of approximately 1,050 per quarter.//2008//
/2009/ Contingent upon the availability of funding, an additional five Parent Resource Specialists have been trained and will be housed this spring at the following five southern counties; Cape May, Cumberland, Burlington, Salem and Gloucester. Funding to support this expansion of

family support resources at the SCHS Case Management Units was identified by SPAN through a parent training grant. This collaborative initiative will bring the total number of case management units with onsite part-time family support up to 15 counties. //2009//
/2010/ Through the federal Parent Training Information Center (PTI) funding, the additional five Parent Resource Specialists continue to be housed in Cape May, Cumberland, Burlington, Salem and Gloucester Counties. This collaborative initiative maintains the total of case management units with part-time onsite family support to 15 counties and additional telephone support to the remaining 6 county units. Funding is being sought to further expand on-site parent support at the remaining counties through a 2009 HRSA sponsored State Implementation Grant, and notice remains pending on that application. //2010//

Parent-to-Parent is a telephone support service that matches trained volunteer support parents with other parents of children who have similar health care needs. Nearly 81 support parents were trained in SFY 2004 and 174 matches were made.
/2007/ Matches remained stable in 2005. In January 2006, the ninth anniversary of NJ Parent to Parent, a major milestone was achieved with celebration of the 1,000 match since inception of the project. In addition, SPAN is piloting an outreach and support program to parents of babies hospitalized in neonatal intensive care, based on the NJ Parent to Parent model.//2007//
/2008/ Parent to Parent is anticipated to lead the planning effort and collaborate with the New Jersey EHDI program in sponsoring the 2nd annual Family Learning Day. The focus of the event is to provide hearing loss related educational materials and resources to parents, children and youth as well as professionals. In 2006, Parent to Parent averaged over 25 parent matches per quarter and continues to outreach and support families of CSHCN.//2008//
/2009/ Parent to Parent continues to train volunteer support parents, having matched 1,380 families to date. Planning for the spring 2009 3rd Family Learning Conference for families of children who are deaf and/or hard of hearing is underway and Parent to Parent is collaborating with the DHSS, Early Hearing Detection and Intervention, Family Centered Care Services staffs; DHS, Division of the Deaf and Hard of Hearing staff, and other non-profit agencies to plan the event. //2009//
/2010/ Parent to Parent has matched 1,436 families to date and trained an additional 546 support parents. Parent to Parent continues to provide outreach and services to underserved communities in the State of New Jersey.

Planning for the 2009, 3rd Family Learning Conference for families of children who are deaf and/or hard of hearing is being finalized. This year the program is planned to be held at the Atlantic Cape Community College in the southern region of the State. Previous conferences were conducted in the northern and central regions of the State, and this event is planned to outreach to families in southern New Jersey that were unable to participate at previous conferences. //2010//

The third program within Family WRAP, Family Voices New Jersey (FVNJ), focuses on education, advocacy, medical home, and expanded outreach to families of CSHCN. The New Jersey Coordinators of FVNJ provided training and technical assistance in the first 9 months of SFY 2004 to approximately 12,000 parents and professionals. A brochure describing Family WRAP is provided to each family served through the county case management units.
/2007/ In 2005, a total of 20,000 combined parent and professional contacts were reported by the FVNJ Coordinators.//2007//
/2008/ FVNJ continued its outreach and support of families of CSHCN, with an average of 7,000 contacts/quarter, providing information and technical assistance to parents and professionals. On average, SPAN reported nearly 11,600 hits to the Family WRAP component of the SPAN website, and 3,335 visits to the Medicaid Managed Care fact sheets.//2008//
//2009//FVNJ continued its efforts to outreach and support families of CSHCN, and provided information and technical assistance to 7,953 parents and providers. //2009//
/2010 /Family Wrap reports an overall total of 34,548 parents and professionals received information, training or technical support through the three components of Family WRAP and

approximately 17,900 hits to the Family WRAP component of the SPAN website. /***//2010//***

SCHEIS and SPAN have successfully collaborated to apply for supplemental funding for Family WRAP activities from local philanthropic organizations including the Essex Healthcare Foundation targeting Essex County and the Van Houten Foundation targeting Bergen and Passaic efforts, and the Health Resources Services Administration's Early Hearing Detection Intervention (EHDI) project. In FY 2004 Family WRAP's involvement with New Jersey's EHDI project included: targeted outreach to parents, organizations, and agencies that provided family support to children who are deaf or hard of hearing; training of 8 volunteer support parents of children that are deaf and/or hard of hearing; and development of a flyer (in English and Spanish) to educate parents about newborn hearing screening follow-up. Expanded cultural competency efforts include recruiting support parents among the Chinese and Haitian/Creole communities to organize focus groups and enhance outreach efforts.
/2010/ In an effort to further expand and better coordinate services to address the six core outcomes for CYSHCN and their families, SCHEIS, SPAN and the New Jersey Academy of Pediatrics have collaborated on the development of a HRSA State Implementation Grant for Systems of Services for CYSHCN. SPAN has submitted the $300,000 application and we anticipate response on that application on or before June 2009. //2010//

C. Organizational Structure

The organizational structure of the New Jersey Title V program has not changed since the submission of the FFY 2002 application. All Maternal and Child Health (MCH) programs including programs for Children with Special Health Care Needs (CSHCN) continue to be organizationally located within the Division of Family Health Services (FHS). All Title V services are under the direction of Celeste Andriot Wood, Assistant Commissioner, Division of FHS.

Attached to this section is an organizational Chart for the Division of Family Health Services.

An organizational chart for the New Jersey Department of Health & Senior Services is available at http://atdhss/hr/orgmain.pdf.
An attachment is included in this section.

D. Other MCH Capacity

Maternal and Child Health Epidemiology Program

The Maternal and Child Health Epidemiology Program (MCH Epi) is under the direction of Lakota Kruse, M.D., M.P.H., Medical Director for the Division of Family Health Services. The Office of the Medical Director provides medical and epidemiological consultation for all the division's programs. The mission of MCH Epi is to promote the health of pregnant women, infants and children through the analysis of trends in maternal and child health data and to facilitate efforts aimed at developing strategies to improve maternal and child health outcomes through the provision of data and completion of applied research projects.

The MCH Epi Program promotes the central collection, integration and analysis of MCH data. Ingrid Morton is the Program Manager for MCH Epi, which is comprised of four research professionals, and two support staff. All research staff members possess extensive experience in statistics, research, evaluation, demography and public health. Additionally, professional staff members have extensive experience with data linking, record matching and epidemiological research. One professional staff position is supported entirely by resources from the MCH Bureau's State Systems Development Initiative (SSDI) grant. The Pregnancy Risk Assessment

Monitoring System (PRAMS) survey is coordinated by the MCH Epi Program.

Maternal, Child and Community Health (MCCH)

MCCH is comprised of two program managers, 39 professionals, and 24 support staff. All staff members are housed in the central office. Dr. Linda Jones-Hicks became the Service Director for MCCH in January 2004. Dr. Jones-Hicks is a pediatrician with specialty training in Adolescent Medicine and experience with several MCH coalitions in New Jersey. Among the professional staff are individuals with nursing, social science, environmental, nutrition, statistical, epidemiology, and other public health backgrounds.
/2007/ MCCH has three major programs: Reproductive and Perinatal Services, Child and Adolescent Health and the Children's Oral Health Education Program.//2007//
/2008/ MCCH is comprised of two program managers, 29 professionals, and 18 support staff. //2008//

/2010/ Reproductive and Perinatal Health Services is staffed by 11 professionals and 5 support personnel and a Program Manager, Sandra Schwarz. The program is responsible for the regional MCH Consortia, Healthy Mothers, Healthy Babies Coalitions, Certificate of Need rules and MCH Consortia regulations, morbidity and mortality reviews, Healthy Start projects, Family Planning, the Black Infant Mortality Reduction Initiative, perinatal addictions and fetal alcohol syndrome prevention projects, post partum wellness initiative and preconceptual health. Resources for staff have been from Federal MCH Block, Federal Title X, Preventive Health and Health Services Block, and Healthy Start Grants.

Child and Adolescent Health is comprised of a staff of 7 professionals, 6 support personnel, 1 paraprofessional and a Program Manager. Resources include: State MCH funds, Federal MCH, and Preventive Health and Health Services Block Grants, Centers for Disease Control and Prevention cooperative agreements for Lead and School Health, an Early Childhood Comprehensive Systems (ECCS) Implementation grant from HRSA, MCHB and State Lead funds. All staff members are housed in the central office. Child and Adolescent Health is headed by a Program Manager and has as its focus early childhood and adolescent health. Early childhood has a coordinator and four professionals and 1 paraprofessional. The Project Coordinator for New Jersey's ECCS grant is included in the early childhood section. The adolescent health section includes school health and the Community Partnership for Healthy Adolescents initiative, and has two professional staff. Child and Adolescent Health staff have varied professional backgrounds including nursing, nutrition, health education, research and data analysis. //2010//
/2007/ The Program Manager for the Child and Adolescent Health Unit is Cynthia Collins.//2007//
/2008/ In concurrence with the NJ Department of Education (DOE) and DHSS, Governor Corzine determined that New Jersey could not assure compliance to the eight elements as mandated in the federal 2007 State Abstinence Education Program application. In particular, New Jersey's concern relates to the required mandate of teaching that abstinence until marriage is the only expected standard of behavior and that sex outside of marriage has harmful psychological and physical effects. As specified in the guidelines for funding, these tenets are not meant to be limited to children only. The State has an inclusive approach to comprehensive sexuality education as specified in the Core Curriculum Content Standards. In addition, N.J.S.A. 18A: 35-4.20 et seq. requires schools to emphasize abstinence and also permits contraception instruction, but the law does not mandate an "abstinence-only" approach as required by Title V funding. Therefore DHSS made the decision not to apply for federal fiscal year (FFY) 2007 State Abstinence Education Program funds from the U.S. Department of Health and Human Services.//2008//
/2009/ In Collaboration with the DOE, New Jersey submitted a successful application to the CDC for a Coordinated School Health Program. Funding in the amount of $420,000 per year began March 1, 2008. This funding provides one dedicated FTE school health position in DHSS, Child and Adolescent Health Unit and two dedicated FTE school health positions in the DOE.
DHSS submitted an application for the CDC in response to a funding opportunity announcement

for a Nutrition, Physical Activity, Obesity (NPAO) Program. Funding in the amount of $922,132 has been requested. If approved, funding would begin June 30, 2008 and support positions and activities in the Office on Nutrition and Fitness. //2009//
/2010/ Due to a state hiring freeze the DOE School Health Coordinator has not been hired. DOE and DHSS are discussing a proposal to present to the CDC project officer.

DHSS was awarded a five year (06/01/2008 thru 05/31/2013) CDC Cooperative Agreement for Nutrition, Physical Activity and Obesity Program in the amount of $815,092. The funding is dedicated to provide infrastructure support to the newly created Office of Nutrition and Fitness. Four staff were reassigned to work in the Office and due to a state hiring freeze, other staff positions have remained vacant. //2010//

The Children's Oral Health Education Program comprised of 1 professional and 1 support staff reports to the Office of the Director. Dr. Beverly Kupiec-Sce coordinates the program which provides age appropriate oral health education to school age children.

Special Child Health and Early Intervention Services (SCHEIS)

Special Child Health and Early Intervention Services (SCHEIS) consists of the following programs and services: Early Identification and Monitoring, Newborn Screening and Genetic Services Program, Family Centered Care Services, and Early Intervention Services System. Gloria Rodriguez is the Director of SCHEIS. All SCHEIS staff members are housed in the central office. Early Intervention System is headed by Terry Harrison, Part C Coordinator. This system provides services to infants and toddlers with disabilities or developmental delays and their families in accordance with Part C of the Individuals with Disabilities Education Act.

/2009/ Dr. Marilyn Gorney-Daley returned to SCHEIS in November 2007. As the Medical Director, she oversees all autism initiatives, including the Governor's Council for Medical Research and Treatment of Autism; she is board certified in General Preventive Medicine and Public Health. //2009//
/2010/ Dr. Marilyn Gorney-Daley is the Medical Director for SCHEIS; she is board certified in General Preventive Medicine and Public Health. Dr. Gorney-Daley oversees all autism initiatives, including the Governor's Council for Medical Research and Treatment of Autism. //2010//

The Early Identification and Monitoring (EIM) Program is responsible for the reporting and monitoring of children with birth defects and special needs (the Special Child Health Services Registry), Early Hearing Detection and Intervention, the New Jersey Center for Birth Defects Research and Prevention and the National Down Syndrome Study. The EIM Program is comprised of a staff of ten professionals, seven support staff, and a Program Manager, Leslie Beres-Sochka, who holds a Master of Science in biostatistics and has over 20 years experience in research, statistical analysis, and database design and management. Resources for staff come from the MCH Block Grant, a HRSA grant for universal newborn hearing screening, and two Centers for Disease Control and Prevention cooperative agreements. An additional 5- year CDC cooperative agreement was awarded to the EIM Program in September 2003. This funding will be utilized to enhance data linkage and exchange between the SCHS Registry and the Family Centered Care Program.
/2007/ The CDC Cooperative agreement for the Centers for Birth Defects Research and Prevention and the NIH funded National Down Syndrome Study ended in 2005. One professional staff member retired and another was reassigned to the MCCH Program.//2007//

The Newborn Screening and Genetic Services Program is responsible for the follow-up of newborns with out-of-range screening results. This program also provides partial support through its grants to specialty care centers and facilities for metabolic and genetic services, pediatric endocrine services, pediatric hematologic services, pediatric pulmonary services and specialized

confirmatory and diagnostic laboratory services. The Newborn Screening and Genetic Services Program is currently comprised of a staff of 8 professionals and two support staff.
/2008/ In addition, there are three vacant Public Health Representative 1 positions and one Public Health Representative 1 Bilingual position. The Newborn Screening Program has requested and received permission to fill these vacant positions and the hiring process is currently underway. Funding for staff, as well as specialized pediatric treatment programs is provided through a Newborn Screening Laboratory fee and MCH Block Grant as well as State designated appropriation. Dr. Tajwar Aamir, a board certified pediatrician, currently serves as the Program Director for Newborn Screening and Genetic Services as well as Medical Director for Special Child Health and Early Intervention Services.//2008//
/2009/ In FY 2008, two open positions for Public Health Representative I were filled. The third position was changed into a bilingual position and a Public Health Representative II-bilingual was hired. This move was necessary in order to better serve the diverse population of New Jersey. The program currently has three open positions, which are one Public Health Representative I, Research Scientist I and a secretarial position. The Program is awaiting exemption determination from the state wide hiring freeze in order to fill these positions. //2009//
//2010// In FY 2009, one open position for a Public Health Representative I, Bilingual, was filled. Vacancies remain for a Public Health Representative I, Research Scientist I and a Senior Public Health Physician. Dr. Marilyn Gorney-Daley, Medical Director for SCHEIS, also serves as the Program Director for Newborn Screening and Genetic Services. //2010//

The Family Centered Care Program (FCCS) is responsible for funding, monitoring, and evaluating services provided by the 21 Title V funded case management units, Family WRAP family support services, 11 child evaluation centers which include 6 FAS Diagnostic Centers, 5 cleft lip/cleft palate centers, 3 tertiary care centers, two organ donor and tissue sharing donor awareness education programs, and the 7 Ryan White Part D funded Statewide Family Centered HIV Care Network sites. Resources for staff come from the MCH Block Grant and from the HRSA AIDS Bureau under Ryan White Part D. This program is comprised of a staff of seven professionals, three support staff, and a Program Manager, Mrs. Pauline Lisciotto, RN, MSN. The Coordinator of Special Child Health Services, Case Management is Mrs. Bonnie Teman, RN, MSN.
/2009/ Mrs. Bonnie Teman, Coordinator, SCHS Case Management and Mrs. Pauline Lisciotto, Program Manager, Family Centered Care Services attended the National Family Voices conference and accepted the Mary Clarkson Professional Partner Commitment to Kids Award on behalf of New Jersey's CSHCN programs efforts to support children and families. //2009//
//2010// Due to the retirement of Ms. Anne Marie Donahue in July 2008, the Specialized Pediatric Services is staffed solely by Ms. Elizabeth Collins, RN, MSN, Coordinator. Likewise, due to the promotions of Ms. Elaine Suenholz, RN, MSN, in April 2008 and Ms. Diana Garzio, RN, MSN in August 2008, Case Management is staffed solely by Ms. Bonnie Teman, RN, MSN, Coordinator. These public health nursing positions remain vacant due to the State hiring freeze. //2010//

All programs within SCHEIS have staff with varied professional backgrounds including nursing, medicine, physical therapy, epidemiology, speech pathology, public health, research, statistics, family counseling, education, and genetic counseling. Both senior level and support staff includes parents of children with special health care needs such as developmental delay, seizure disorder, specific genetic syndromes, and asthma.

E. State Agency Coordination

New Jersey has prided itself on its regional MCH services and programs, which have been provided through the Maternal Child Health Consortia (MCHC), an established regionalized network of maternal and child health providers with emphasis on prevention and community-based activities. The consortia are charged with developing regional perinatal and pediatric plans, total quality improvement systems, professional and consumer education, transport systems, data analysis, and infant follow-up programs. Specific programs include the activities of

eight Healthy Mothers Healthy Babies Coalitions, Perinatal Addictions Prevention Projects, Post Partum Depression education projects, preconceptional health counseling, regional Childhood Lead Poisoning Prevention Coalitions, and facilitation of the Black Infant Mortality Reduction initiative. These activities have continued to expand during the reporting period and have gained the attention of other department programs.

A representative from Reproductive and Perinatal Health Services serves as the liaison to two of the NJ Healthy Start Projects and is responsible for the collaboration and coordination of the New Jersey Healthy Start Projects with Department activities and programs. This collaboration helps to assure integration of services and the effective use of both State and Healthy Start funds to eliminate disparities in women's and infant's health.

The DHSS has a seat on the Child Fatality and Near Fatality Review Board (CFNFRB). Staff from Family Health Services represents the Commissioner of Health and Senior Services on this board. A major outcome of the relationship with the CFNFRB is to work towards a coordinated effort of mortality/morbidity review in New Jersey.

Staff from Reproductive and Perinatal Health Services participates in the Steering committee for Promoting Safe and Stable Families (Title IV-B) within the Department of Human Services. Efforts continue to enhance and increase the community-based delivery of family-preservation, family support, time-limited family re-unification and adoption promotion and support services.

/2009/ The Perinatal Addictions Prevention Project addresses prevention of Fetal Alcohol Spectrum Disorders (FASD) and other substance use/abuse issues through screening, prevention, education and referral to treatment. Through the Office of Prevention of Mental Retardation and Developmental Disabilities (OPMRDD), the Fetal Alcohol Spectrum Disorder (FASD) Task Force was convened to assess and make recommendations regarding FASD prevention. The Task Force has expanded its focus to include alcohol, tobacco and other drug use during pregnancy. The five year strategic plan was finalized in 2008. //2009//

In SFY 2002, state funds became available for establishment of prevention, diagnosis and treatment centers for Fetal Alcohol Spectrum Disorders (FASD). In SFY 2003, $450,000 was again awarded to SCHEIS, Specialized Pediatric Services, to continue the Centers of Excellence for diagnosis, treatment, and education. With these funds, four child evaluation centers (2 are multi-agency collaborative projects), continue to function as centers of excellence and in FY 2003, one center also received a CDC regional centers grant to develop a core curriculum to be used nationwide to educate health care professionals on FASD. The staff of the Centers are in contact with the FASD Task Force, the MCH Consortia, the Department of Education, The ARC, and other state and community agencies who serve the FASD community. Additional funds in the amount of $400,000 were awarded to the Reproductive and Perinatal Health Services for the Perinatal Addictions Prevention Project through the MCH Consortia. This program provides for professional and community education regarding the use and abuse of alcohol, drugs and tobacco during pregnancy. This regional approach reaches both the public and private sector providers of care to ensure access to risk reduction assessment and intervention.

A function of the FASD Centers is to provide FASD community based outreach and education for the public and providers. Audiences targeted for outreach and education included Department of Children and Families, schools, parent-teacher organizations, Head Start, medical grand rounds and radio public service announcements. The Centers also developed and maintain an education and resource based web site, www.fasnj.org, which is in its fourth year of operation.

Teen pregnancy prevention is at the forefront in NJ. The Advisory Council on Adolescent Pregnancy Prevention held its first meeting in April 1999. The Council is in, but not of, the Department of Health and Senior Services. Representation includes designees from the Departments of Human Services, Education, Community Affairs, and Labor. Some of the Council's responsibilities include development of policy proposals, promoting a coordinated and

comprehensive approach to the problems of adolescent pregnancy and parenting, and promoting community input and communication. The Council has established working groups on data, male involvement, school-based services and teen parenting. In 2003, the Council developed a three-year strategic plan to guide the work of the Council and focus on specific areas of interest.

The WorkFirst Teen Pregnancy Prevention Work Group is another example of successful interdepartmental collaboration. The Department of Human Services serves as lead agency for this initiative and the group has been charged with planning, developing and implementing new initiatives. Using TANF grant funds, $1.1 million was allocated for Teen Pregnancy Prevention Initiatives. Youth-to-youth programs and mentoring projects are now underway and a Teen Pregnancy Resource Center has been established. MCCH staff participate along with representatives of the Departments of Human Services and Education.

More emphasis is also being placed on facilitating health and safety in child care settings. Collaboration between the DHSS and the NJ Department of Human Services, Division of Family Development over the past four years has resulted in the establishment of an infrastructure to promote the health and development of young children in child care settings. A child care health consultant coordinator is on staff at each of NJ's 21 county child care resource and referral agencies. Nurses from local health departments and other community agencies have been trained to be health consultants to their local child care providers.

The collaboration between DHSS and the NJ Department of Children and Families includes not only the Division of Family Development but also the Office of Child Care Licensing. Staff from both Divisions actively participate on the Early Childhood Comprehensive Systems Team, HCCNJ Executive Board, the PLAY Task Force, and the Medication in Child Care and Communicable Disease Committees. A particular benefit from the collaboration with the Office of Child Care Licensing has been the ability to make recommendations based on the National Health and Safety Performance Standards for Out-of-Home Child Care Programs that have strengthened child care regulations in NJ concerning health and safety issues.

/2007/ The first meeting of the Public Health Practice Standards Task Force for Infants and Preschool Children was convened on February 23, 2005. Members of that Task Force include representatives from public health nursing, county Child Care Health Consultants Coordinators, child care resource and referral agencies, health officers, child care center and family child care providers, Head Start, NJ State Nurses Association, NJ Society for Public Health Educators and parents. Four strategies (child health conference guidelines for service, child care health consultation, home visiting and professional development to support the first three) have been selected with recommendations to be made to the Office of Public Health Infrastructure by October 1, 2006.//2007//
/2008/ Recommendations were presented to the Office of Public Health Infrastructure in October 2006. The priority for the current grant year is the development of assessment, documentation, tracking and evaluation tools to support the implementation of the recommendations. Also to be developed is a Maternal and Child Health Community Assessment Tool to identify the needs of the early childhood population and to set priorities accordingly. The quarterly Child Health Regional Network meetings will be utilized as one of the professional development venues to support the Performance Standards recommendations.//2008//

/2008/ The theme for the annual Health in Child Care Conference in May 2007 is "Partnerships for Healthy Lifestyles". Margaret Fisher, MD, FAAP, Medical Director of The Children's Hospital at Monmouth Medical Center, presented the keynote address concerning preventing obesity beginning in early childhood. Participants in the four-day child care health consultation training have included a number of school nurses providing health services in Abbott preschool programs, particularly in Essex and Mercer County.//2008//
/2009/ The theme for the Annual Health in Child Care Conference in May 2008 was "Making a Difference for All Children". A keynote panel presented on "Hope for Children with Autism: Research & Experience."//2009//

/2008/ A collaborative project with Prevent Child Abuse New Jersey and the Prevention Subcommittee of the NJ Task Force on Child Abuse and Neglect, Home Visiting Workgroup, resulted in the development of a model for a Comprehensive System for Home Visiting in New Jersey. This work also resulted in the application and award of a Robert Wood Johnson grant for a statewide Home Visiting Training Academy. One of the priorities for 2007 is the development and piloting of a training curriculum for public health nurses.//2008//
/2009/ A two-day public health nurse home visiting curriculum pilot training was conducted on June 15 and 22, 2007. Participants to this training included 17 public health nurses from seven counties. Incorporated into the pilot training was the piloting of various assessment and documentation tools. Most important was the Maternal and Child Health Community Assessment tool, designed to be used to identify early childhood population needs and gaps as well as to set priorities for service delivery within their identified community.//2009//

In January 2004 the DHSS initiated a process to develop an Early Childhood Comprehensive Systems (ECCS) Plan for NJ and in September 2005 NJ was awarded a grant to implement its plan. Partners with DHSS on the ECCS Planning Team include the NJ Departments of Human Services, Education, Community Affairs, Environmental Protection, and Labor, and the Juvenile Justice Commission. Community partners include the Association for Children of NJ, the Youth Consultation Service, Healthy Child Care NJ, Children's Futures, and the University of Medicine and Dentistry of NJ. The Planning Team also includes three parent members. To facilitate the process, the ECCS team is collaborating with an existing statewide program, the BUILD NJ Partners for Early Learning initiative and the Department of Human Services, Office of Children's Services, Division of Prevention and Community Partnerships (OCS/DPCP).

/2007/ As part of the OCS/DPCP efforts for systems building, DHSS was invited to join with the Department of Education to pilot a Strengthening Families Initiative (SFI) in eight communities statewide. The SFI was launched on January 31, 2006 with teams comprised of individuals from the participating Abbott Pre-K programs and child care centers, and parents from each of those sites, and representatives from the health, education, child care and social services community who will be implementing SFI principles in each of the pilot sites.//2007//

/2008/ Due to reorganization within the Department of Human Services and the subsequent establishment of the Department of Children and Families, the SFI activities were interrupted but reconvened in the fall of 2006. The Division of Prevention and Community Partnerships is supporting the efforts of SFI and has also announced the expansion of home visiting grants that promote healthy growth and development of children and preventing child abuse and neglect through parent education and family support. The Early Childhood Health Link quarterly newsletter is being used to promote the adoption of SFI principles in child care centers across the state. The lead article in the 2007 Spring Edition of the newsletter will be the first in a series of articles to provide ways that early childhood professionals can support families in their children's healthy growth and early learning. With funding from the ECCS a three-day Parent Leadership training was conducted in October 2006 by the Statewide Parent Advocacy Network with 30 parents statewide to enhance parent involvement in advocating for the needs of children and their families.//2008//
/2009/ This year the Division of Prevention & Community Partnership (DPCP) has worked closely with eight pilot sites monitoring their progress as they implemented the Strengthening Families Initiative Framework. A statewide Strengthening Families Task Force played a key role in promotion the program and developing strategies to incorporate its use throughout the state.//2009//

The Children's Oral Health Education Program works with a variety of collaborating partners on oral health education age appropriate activities. The DHSS maintains a Memorandum of Agreement (MOA) with the University of Medicine and Dentistry-NJ Dental School for the provision of dental health consultative services to the Program. Arnold Rosenheck, D.M.D.,

Assistant Dean at UMDNJ continues to serve as dental consultant.
/2008/ In support of the ECCS grant goals and objectives for early childhood systems building, a collaboration with the Head Start-State Collaboration Project, a federal grant was submitted and awarded to convene an Early Childhood Oral Health Forum in May 2007 to address the oral health needs of underserved children in Head Start, Early Head Start, and children in child care settings. The forum was held on May 10th and the outcome from the forum provided information for the development of a state wide pediatrics oral health plan for children zero to six. The plan is expected to be completed in the spring of 2008.//2008//

School health collaboration and coordination is accomplished through a school health liaison position within the Adolescent Health Section. The Departments of Education and DHSS staff have developed joint statements and a Strategic Plan for School Age Health signed by both Commissioners. The strategic plan affirms both departments' support for comprehensive school health programs, with a particular focus on the 31 special needs school districts.

In February 2005, an intradepartmental meeting was held to build relationships and improve intradepartmental communication; identifying existing resources (programs/services) so that a "Resource Guide to School Health Programs" can be developed; identify a plan for marketing the adoption of the Coordinated School Health Program (CSHP) model across all State Departments; and strengthen the joint statement between the Departments by establishing an interdepartmental memorandum of understanding (MOU) that would outline the roles and responsibilities of each Department. The intent of the MOU would be to institutionalize a CSHP within the current structure of the NJ state government. In other words, create infrastructure capacity for a CSHP.
/2007/ The "Resource Guide to School Health Programs" report was created and distributed.//2007//
/2008/ The "Resource Guide to School Health Programs" was updated and distributed.//2008//
/2009/ DHSS/Collaborated with DOE on its successful application to CDC-DASH for a Coordinated School Health Program. Funding began on March 1, 2008. Funding will provide one FTE School Health Coordinator in DHSS. //2009//

Another collaborative training between DHSS and the Department of Education and facilitated by the Association of Maternal and Child Health Programs (AMCHP), took place in January 2005. The training focused on strengthening a State and Education Agency Partnership to Improve HIV, STD and Unintended and Teen Pregnancy Prevention in Schools. As a result of attendance at this training, NJ's draft vision statement is "To create and maintain a collaborative infrastructure that maximizes resources and results in more assessable and effective sexual health programs (including health services) for youth". In the next 6 months, the NJ team plans to: 1) contact and invite School-Based Youth Service Programs and Family Planning to join the State team; and 2) DHSS/DOE to share in scheduling and planning 2 meetings between February and June 2005 to discuss funding sources/budget, grant priorities, objectives, projects and activities.
/2007/ In January 2006 the partnership scheduled a meeting with Public/Private Ventures to present information on the Annie E. Casey Foundation's Plain Talk model program for possible joint funding.//2007//
/2008/ In January 2007, FHS provided funding support to the Division on AIDS for the implementation of the Annie E Casey Foundation's model program: Plain Talk in Vineland Cumberland County "Plain Talk" is a pro-active, community-based intervention that outreaches to adults-parents, family or other supportive adults -- and educates them on adult/teen communication related to responsible sex, access to contraception and comprehensive sexual education. It is proven to be effective in reducing teen pregnancy, STI's and HIV/AIDS in Latino, African American, white and Asian teens. The cost of implementing this model in NJ is approximately $85,000 for a community size of 5-7,000.//2008//
/2009/ The Plain Talk Coordinator and the Executive Director of the implementing agency, Martin Luther King in Vineland, both vacated their positions after the completion of the mapping process. This has resulted in a significant delay in program implementation, with the potential threat that Plain Talk will not implemented. //2009//

The Community Partnership for Healthy Adolescents (CPHA) is coordinating with the Office of Public Health Infrastructure's Community Health Partnerships. The Community Health Partnerships are being implemented in each NJ county with funding from the CDC and NACCHO. The funding supports a team that includes a planner, public health partnership coordinator, health educator/"risk communicator", public health nurse, information technology person, secretary, and perhaps, a part-time medical director. The Community Health Partnerships were established in the fall of 2004 and by spring of 2005, they are expected to be implementing MAPP (Mobilizing for Action through Planning and Partnerships) where information and data will be collected for a comprehensive needs assessment.
/2007/ In 2006 the Community Health Partnerships are expected to begin the MAPP (Mobilizing for Action through Planning and Partnerships) process, collecting information and data for a comprehensive needs assessment.//2007//
/2008/ The Community Health Partnerships have completed their comprehensive needs assessment of the MAPP process. The top five prior public health issues, by county, should be available by June 2007.//2008//
/2009/ The CPHA Adolescent Coordinators have been given contact information for the Community Health Partnership Coordinators and encouraged to partner/coordinate/collaborate on shared issues including nutrition, physical activity and obesity; violence; and school health. //2009//

Coordination between the State's Primary Care Association and Federally Qualified Health Centers continues. In 2005, a new Office of Primary Care was created. The Coordinator of Primary Care works out of the Office of Primary Care. The Federal Primary Care Cooperative Agreement is administered by this office.

Special Child Health and Early Intervention Services (SCHEIS) and the Statewide Parent Advocacy Network (SPAN) continue to collaborate to improve services to CSHCN, including transition to adulthood services. The Essex County SPAN Resource Specialist, (parent of a CSHCN) initiated a pilot project on transition to adulthood. A transition to adulthood information packet template evolved from the pilot project. County specific resources are incorporated to include local resources, and the packet is given to youth served through the SCHEIS case management units.
/2008/ In addition, a collaboration between SCHEIS, SPAN, the Academies at Englewood, NJ Council on Developmental Disabilities and Champions for Progress has produced a NJ specific transition to adulthood compact disc (CD) for use by youth, parents and professionals. The CD was widely distributed statewide. //2008//

To assist families of children with special needs in navigating the Medicaid Managed Care system a Medicaid Managed Care Alliance was formed in October 1999. This alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCHEIS case managers and others. It promotes collaboration between HMO case managers and the County Case Management Unit staff which has proven valuable in problem solving access to appropriate specialized pediatric services, payments for non-covered medical and or social services for CSHCN, and smoother transition between systems of care such as Early Intervention, Medicaid model waivers, and special education. In October 2002, Medicaid Managed Care Alliance members were invited to participate in a meeting focusing on the reorganization of SCHEIS services and ongoing efforts to achieving community based systems of care for CSHCN and their families. This meeting successfully linked SCHEIS state staff and grantees with parents, Medicaid HMO case managers and the Department of Human Services Quality Assurance and Monitoring staff, and led to closer working relationships at the county and provider agency level. This cooperative relationship continues between the county case management units, the Medicaid HMO case mangers and the DHS Quality Assurance and Monitoring staff. Likewise, it has facilitated dialogue between the specialized pediatric services' providers and families in easing access to pediatric specialty care.
/2009/SCHEIS representatives participate on the statewide Medical Assistance Advisory Council (MAAC). Administered by the DHS, MAAC participants include intergovernmental, community

based providers, consumers and advocates. This workgroup provides a forum for discussion of process, updates and changes to State Medicaid programs that could affect services to the disabled community, and affords participants the opportunity to provide input into access to services.

/2009/ The Reproductive and Perinatal Health Services (RPHS) coordinated the Preconceptional Health Promotion/Folic Acid Initiatives in 2007. More recently in 2008, FCCS staff participated in the Medical Assistance Advisory Council (MAAC). Housed in the Department of Human Services, the MAAC is a formal interagency committee with a diverse membership representing managed care providers, consumers, advocates and State agencies. The Council meets quarterly and the Director of the Division of Medical Assistance and Health Services provides an update on Medicaid, especially Medicaid managed care. The MAAC provides a forum for sharing updates and issues as well as lack of folic acid intake, were selected for educational emphasis through the six Maternal and Child Health Consortia (MCHC). The RPHS continued its affiliation with the National Council on Folic Acid (NCFA), and received monthly "Folic Acid News" updates that were, electronically, transmitted to the Folic Acid Coalition of NJ membership. //2009//

/2009/ During CY 2007, the Reproductive and Perinatal Health Services distributed 11,010 preconception health brochures, 3,230 folic acid, and 3,885 Postpartum Depression (PPD) equal to a grand total of 18,125 brochures in English and Spanish among target group populations. These materials were disseminated through the eight Healthy Mothers, Healthy Babies (HMHB) Coalitions, the Family Health Line that operates the 1-800-328-3838 hotline, health fairs and community events. Some of the events were the Latino Expo Women's Trauma Conference, the Adolescent Health Institute with the Binational Health Fair of the United States and El Salvador//2009//

/2007/ In 2005, SCHEIS and the five Cleft Lip Cleft Palate Craniofacial Centers comprising the NJ Federation of Cleft Palate-Craniofacial Centers, Inc. initiated dialogue with the Department of Human Services, Office of Medicaid Managed Care dental consultant to facilitate access to comprehensive center based care. Issues discussed included reimbursement for team services and coordination of in and out of network benefits. This dialogue has further developed and a productive meeting was conducted in March of 2006, including representatives from Medicaid, the Medicaid Managed Care Organizations, the Cleft Lip Cleft Palate Craniofacial Centers, the regional Medicaid Assistance Customer Centers and State staff to network, clarify roles and ensure that patients may be treated by a team without fragmentation of care or services.//2007// /2008/ A positive outcome of this collaboration was a clearer understanding of roles and responsibilities as well as communication regarding clients' needs.//2008//

SCHEIS has a seat on the Division of the Deaf and Hard of Hearing's (DDHH) Advisory Council. EIM Staff and staff from the DDHH have implemented quarterly meetings in order to coordinate and implement activities to strengthen the Early Hearing Detection and Intervention Program. /2008/ SCHEIS staff provided in-kind support at Family Day, a parent training and resource day held at Katzenback School for the Deaf. This collaborative effort organized by the DDHH served approximately 50 families of children that are deaf or hard of hearing as well as nearly 50 professionals.//2008//

The "Children's System of Care" initiative has been initiated in three (3) counties, which will be a new system of comprehensive services for children with mental illness or severe emotional and behavioral problems. State funds of $39 million have been committed to create this centralized system. SCHEIS staff both welcome and anticipate collaborative efforts regarding this initiative. Currently, SCHEIS staff is represented on the Community Mental Health Board and Planning Council.

Through the activities of the NJ Center for Birth Defects Research and Prevention, staff from Special Child Health and Early Intervention Services are building collaborative relationships with numerous agencies in NJ. Additionally, Centers' staff has developed a strong network with the

other ten national Centers and other researchers. The focuses of the collaborations have been to improve the surveillance of birth defects and to initiate a variety of research projects to further the understanding of the causes of birth defects. Among the funded projects is the formation of a fetal abnormality registry, which will document the occurrence of birth defects among pregnancies as opposed to live births. This data is critical for calculating accurate rates of the occurrence of birth defects, including better information on the evaluation of the impact of folic acid on pregnancies affected by neural tube defects. Other examples of local research projects are a study of hypercoagulability study and the investigation of the role of endocrine disruptors on the occurrence of hypospadias.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicators are presented individually with multi-year data.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	54.4	47.7	50.2	49.2	43.5
Numerator	3138	2687	2801	2741	2424
Denominator	577339	563900	557980	556673	557421
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Denominator of 2008 from Population Division, US Census Bureau, http://www.census.gov/popest/states/asrh/tables/SC-EST2008-01.xls

Final 2008 data will be available in 2011.

Notes - 2007

Denominator of 2007 from Population Division, US Census Bureau, May 1, 2008.

Final 2007 data will be available in 2010.

Notes - 2006

Source: 2006 Hospital Discharge Records from the New Jersey DHSS Health Care Financing Systems.
Hospital discharge records count unique hospital stays for children not unique children hospitalized.

Narrative:

The DHSS funds the American Lung Association of MidAltantic (ALAMid), to support the infrastructure of the Pediatric/Adult NJ Jersey Thoracic Society. It has developed the "Pathway to Asthma Control in NJ," that outlines strategies and initiatives to address the asthma burden.

PACNJ maintains 6 task forces including: Quality, Community, Schools, Child Care, Environment, and Evaluation. The 6 task forces are an integral component to PACNJ's success. The task forces meet to identify, review and design the various objectives and interventions. With the support of staff and resources from PACNJ and its member organizations, the task forces design and implement the various strategies/activities identified in the implementation plan. The Asthma Coordinator and Epidemiologist for FHS serves on the PACNJ Coordinating Committee. The Coordinator is co-chair of the Environmental Task Force and the Epidemiologist is co-chair of the Evaluation Task Force. Other state staff, particularly those on the State Asthma Committee, attend PACNJ meetings and participate in activities.

/2009/ The Asthma Awareness and Education Program (AAEP) and PACNJ redefined and expanded its scope in addressing asthma statewide, the major goal will be to: improve health outcomes for NJ residents with asthma. This goal will be accomplished through: 1) a delivery of care systems change in the NJ FQHCs; 2) increasing the use of Asthma Treatment Plans (ATPs); 3) improving provider and consumer knowledge of asthma management; 4) creating a systems change in schools and day care centers to accommodate a healthy environment for children with asthma; 5) reporting work related asthma triggers and providing interventions to prevent the occurrence of asthma-related emergencies in the workplace; 6) creating a system that provides feedback to FQHCs regarding their patients that visit the ED and which triggers follow-up care by the FQHCs for those patients; and 7) implementing public health activities to reduce asthma mortality and morbidity, with particular emphasis on asthma in children and other disproportionately affected populations.
Significant accomplishments include:

On October 2007, the Third Annual NJ Asthma Summit was held with over 230 healthcare professionals attending the half-day event. The conference focused on various approaches to asthma management and the objectives included: 1) Increase understanding of the CDC approach to addressing asthma; 2) Enhance awareness about the role of cultural competency in the management of asthma; 3) Increase knowledge of work-related asthma and associated interventions; and 4) Increase understanding of the importance of environmental exposure in the control of asthma.//2009//

/2010/ PACNJ is developing a rapport with potential organizations, in order to sustain the Coalition and achieve the activities outlined in the workplan. PACNJ has been dedicated to improving asthma management for over six (6) years and used as a national Coalition model; however, the sustainability of the Coalition is in jeopardy as a result of decreased funds. Currently, the AAEP receives level funding from CDC; however, the Chronic Disease and Prevention Unit has had to utilize Preventive Health and Health Services Block Grant (PHHSBG) funds during the last two (2) budget periods to provide level funding to PACNJ. The PHHSBG funds are decreasing annually, so this is an unstable source of continued funds. As a result, PACNJ is actively seeking additional funding opportunities to continue the exceptional work of the Coalition. During this quarter, PACNJ representatives met with Merck, AstraZeneca Novartis and GlaxoSmithKline to identify partnerships that would lead to sustainability of the Coalition.
The AAEP staff serves as liaison to facilitate collaborations with various internal and external stakeholders to ensure the implementation and accomplishment of PACNJ's work plan. Listed below are some highlights:

- The PACNJ has partnered with the NJ Public Employee Occupational Safety and Health Program (NJ PEOSH) to provide indoor air quality training. The NJ Indoor Air Quality Tools for Schools one-day training required for the AFSA would be replaced with the PEOSH Designated Persons Indoor Air Quality training. This PEOSH training is a 2-hour free session which would include PACNJ slides on the relationship between indoor air quality and respiratory problems.
- The revised Asthma Treatment Plan (ATP) was field tested by physicians from FQHCs and throughout the state. The revised ATP has been translated into seven languages

(Chinese, French Creole, Korean, Spanish, Portuguese, Gujarati, Tagalog) based on the OMMH population statistics. The PACNJ has implemented several strategies to increase the utilization of the ATP statewide.
- The ATP was created in a "fillable- savable" format and posted on the NJ Chapter of the American Academy of Pediatrics website to be downloaded and attached to a patient's electronic records.
- The NJ Healthcare Quality Institute has offered to post the PACNJ ATP on their website.
- The PACNJ will add the NJ Department of Education logo to the form and that will increase use by the school nurses.
- Some schools have posted the form on their websites.
- The Visiting Nurses of Central NJ have their staff using our ATP and she has linked to it in their system. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	94.7	94.7	0.0	90.5	92.0
Numerator	35668	35668	0	36166	36639
Denominator	37646	37646	56371	39971	39805
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 4/2/2009.

Notes - 2007
Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/17/2008.

Notes - 2006
Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/15/2007.

Numerator: 56.371
Denominator: 39,762

Numerator exceeds denominator due to multiple screens reported for the same individual under 1 year of age.

Narrative:
Medicaid in NJ is administered by the Division of Medical Assistance and Health Services (DMAHS) in the NJ Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been

distributing these materials to the parents of children enrolled in Medicaid.

One of the major focuses of the Childhood Lead Poisoning Prevention Projects (CLPPP) is to promote proper use of preventive health services by the families of children who are lead burdened and at high risk of preventable health and developmental problems. CLPPP nurse case managers work with the parents of these children to encourage their enrollment in Medicaid or NJ FamilyCare (if eligible), and the use of preventive and primary care pediatric services, particularly immunization and lead screening. There are CLPPPs in 13 communities.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	90.5	92.0
Numerator	0	0	0	36166	36639
Denominator	1	1	1	39971	39805
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data for HSCI #3 is currently not available. An estimate of the indicator using the percentage of periodic screenings for all New Jersey FamilyCare enrollees under age 1 is available from the Annual EPSDT Participant Report. The estimate for 2008 is 36,639 / 39,805 = 92%.

Notes - 2007
Data for HSCI #3 is currently not available. An estimate of the indicator using the percentage of periodic screenings for all New Jersey FamilyCare enrollees under age 1 is available from the Annual EPSDT Participant Report. The estimate for 2007 is 36,166 / 39,971 = 90.5%.

Notes - 2006
Data for HSCI #3 is currently not available.

Narrative:
New Jersey FamilyCare is New Jersey's SCHIP. It is administered by the Division of Medical Assistance and Health Services (DMAHS) in the New Jersey Department of Human Services. DMAHS and DHSS have collaborated on the development of educational materials on the importance of preventive health services for young children, with an emphasis on the services included in EPSDT. DMAHS has been distributing these materials to the parents of children enrolled in NJ FamilyCare.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	65.2	65.3	65.0	65.8	64.8
Numerator	72865	72085	72675	72506	70714
Denominator	111749	110364	111727	110168	109198
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source provisional 2008 Electronic Birth Certificate file.
HSCI #04 - 2008 provisional data is for percent of NEWBORNS

Final 2008 data will be available in 2010.

Notes - 2007
Source: 2007 Electronic Birth Certificate file.
HSCI #04 - 2007 data is for percent of NEWBORNS

Notes - 2006
Source 2006 Electronic Birth Certificate file.
HSCI #04 - 2006 data is for percent of NEWBORNS

Narrative:
The Healthy Mothers, Healthy Babies (HM, HB) Coalitions promote early and continued prenatal care through community education and outreach. Education is provided to both the consumer and the provider. Consumers are educated on the importance of prenatal care at community events and at formal and informal education sessions. Educational sessions are held in the community at housing developments and places of worship and at provider locations such as the WIC clinic and Social Service office. Health and social service providers are educated on how to eliminate barriers to the receipt of early and continued prenatal care including cultural competency, flexible scheduling, public transportation friendly locations and hiring of multi lingual, multi cultural staff. Outreach efforts included door to door canvassing to identify pregnant women and connect them to care, case management of high risk women to ensure the continued receipt of care and locating pregnant women who have missed a prenatal appointment and reconnecting them to care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	97.5	57.7	59.4	61.8	56.0
Numerator	181724	290478	317312	335797	338979
Denominator	186477	503008	534469	542985	605041
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 4/2/2009.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimatation of Medicaid eligibles receiving a service paid by the Medicaid Program.

Notes - 2007
Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/17/2008.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimatation of Medicaid eligibles receiving a service paid by the Medicaid Program. A report that documents Medicaid eligibles receiving a service paid by the Medicaid Program has been requested but is not available from DHS. Monthly enrollments are available at their website http://www.state.nj.us/humanservices/dmahs/enrollment_reports.html

Notes - 2006
Source: FORM CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services dated 3/15/2007.

Numerator reports eligibles (0-21 yrs) receiving at least one initial or periodic screen which is an under estimatation of Medicaid eligibles receiving a service paid by the Medicaid Program.

Narrative:
The need for health insurance among children in NJ is great and may be growing as a result of the current economic downturn. Providing services to all potentially Medicaid-eligible children is a challenge that requires the timely identification of uninsured children and will require the collaborative efforts of multiple state departments.

Many families are not aware of the availability of free or low cost health insurance programs. Others are overwhelmed by the requirements and information necessary for the enrollment and renewal processes or are unable to pay required monthly premiums and either never enroll or drop off the rolls each month despite being eligible for Medicaid or NJ FamilyCare. Many reasons are cited as barriers to enrollment and retention including: language barriers, concerns regarding immigration status, financial hardships, mistrust of government programs and inability to meet documentation requirements.

The New Jersey Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., New Jersey Policy Perspective, Association for Children of New Jersey (ACNJ), Legal Services of New Jersey, the Departments

of Health and Senior Services, Human Services, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, the Office of the Child Advocate and a public member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings.

The Work Group held discussions with key state health program experts from Pennsylvania, Illinois, Virginia and California and national experts. The Work Group gathered information from these and other states as well as data on the Medicaid, NJ FamilyCare and ADVANTAGE programs.

Data from Rutgers Center for State Health Policy indicate that 293,790 New Jersey children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07. Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid. According to information from DHS, Division of Family Development (DFD), the recession has caused a 50 percent increase in the number of individuals requesting assistance directly from the County Welfare Agencies from December 2007 to December 2008.

New Jersey is currently receiving other data on the number of uninsured children through information provided on the NJ 1040 state income tax form. Tax filers were required to identify on their NJ 1040 state income tax form whether or not their dependents currently have health insurance. Recognizing that this is self-reported data, tax returns filed by New Jersey residents through March 31, 2009, indicate that close to 360,000 children were identified by their parents/guardians as uninsured. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in New Jersey will continue to grow.

Recent changes in federal law give states new opportunities to streamline procedures for enrolling children in health insurance programs and improving the efficiency and effectiveness of enrollment and retention practices. New Jersey is the first state to take advantage of these new opportunities and is in the midst of executing an unprecedented direct outreach campaign. New Jersey developed an Express application for enrolling children in NJ FamilyCare and Medicaid and is mailing it to the households of the nearly 360,000 children who were identified as uninsured on state tax returns.

Based on the Work Group's research and discussion, barriers and recommendations were identified. A report, New Jersey FamilyCare Outreach, Enrollment and Retention Report May 2009, was produced (http://www.acnj.org/admin.asp?uri=2081&action=15&di=1442&ext=pdf&view=yes) which identifies findings and recommendations to help meet goals of the Reform Act.

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed, in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	33.9	33.3	39.9	43.7	44.6
Numerator	31823	36065	41222	51042	53714
Denominator	93858	108419	103251	116822	120383
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services
2008 report dated 4/2/2009.

Notes - 2007
Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services
2007 report dated 3/17/2008.

Notes - 2006
Source: Form CMS-416: ANNUAL EPSDT PARTICIPATION REPORT from the NJ Department of Human Services
2006 report dated 3/15/2007.

Narrative:
Based upon 2007 data, a total of 51,042 (43.7%) eligible 6 -- 9 year old children received dental services during 2007 out of 116,822 children eligible for EPSDT services. Dental initiatives undertaken to promote utilization of dental services are:
-MD Education Regarding Dental Referrals -- EPSDT Screenings: A letter was sent to all Medicaid/NJ FamilyCare Primary Care Physicians (General Practice, Family Practice, Internal Medicine, Pediatricians) and Nurse Practitioners (Family, Pediatrics, Community Health, School Health) enlisting their help in the eradication of childhood dental disease by performing a dental inspection during the EPSDT physical examination and making referrals to a dentist within the timeframes recommended by the Medicaid/NJ FamilyCare program or whenever dental disease is identified.
• Oral Health Stuffer: A stuffer, aimed at increasing utilization of dental services by educating beneficiaries and/or parent/caretakers about the importance of good oral health and the relationship to good overall health, was developed and distributed to Medicaid/NJ FamilyCare families.
• Quarterly Dental Director's Meetings: Office of Quality Assurance conducts quarterly meetings with the HMO dental directors to discuss quality issues including EPSDT.
• Annual Report of EPSDT Performance Measures: The Office of Quality Assurance contracts with the Peer Review Organization of New Jersey to conduct an annual study of HMO EPSDT performance.
• HMO Annual Assessment: DMAHS conducts annual assessments of HMO performance, which includes questions in the dental element regarding measures taken to improve utilization of dental services for EPSDT eligibles.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	62.5	60.0	60.0	58.4	59.7
Numerator	5000	4800	4500	4500	4600
Denominator	8000	8000	7500	7700	7700
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Estimated by SCHEIS from monthly SSI reports. Final 2008 data will be available in 2010.

Notes - 2007
Estimated by SCHEIS from monthly SSI reports.

Notes - 2006
Estimated by SCHEIS from monthly SSI reports.

Narrative:
SCHEIS continues to ensure that Supplemental Security Income (SSI) beneficiaries less than 16 years old received rehabilitation services. Although SCHEIS does not provide direct rehabilitative services to SSI beneficiaries, the program does provide the outreach and case management services to ensure that SSI beneficiaries receive these necessary services. In New Jersey, SSI beneficiaries who meet family income guidelines are eligible for comprehensive Medicaid benefits, which include the rehabilitative services of audiology, physical, occupational, and speech therapy. All New Jersey children applying for SSI disability are referred by the State SCHEIS office to the County Case Management Units through a letter of agreement with New Jersey Department of Labor, Disability Determinations.

In 2004, approximately 3100 SSI beneficiaries less than 16 years old will have had an Individual Service Plan including rehabilitative services developed for them by the County Case Management Units. Approximately 25% of the children in active case management caseload are SSI recipients. In an effort to improve outreach to SSI beneficiaries, the Department has modified the database forwarded by Disability Determinations to access beneficiary's telephone numbers. It is anticipated that this additional information will improve outreach efforts and result in an increase in SSI beneficiaries served.
/2007/ In 2005, approximately 3,000 children served through County Case Management were identified as SSI recipients. The referral process is targeted for update in 2007 to improve transmission and management of data as well as follow-up and monitoring. Electronic transmission of SSI data from the State office to the County Case Management Units will be explored and piloted.//2007//
/2008/ Approximately 3,000 children served through the County Case Management Units were identified in 2006, and 26% of the children in the active case management caseload were SSI beneficiaries. Efforts to revise the report were successful in reducing duplicate referrals per month. Plans for 2007 include further revising the report format to presort live and expired referrals, and piloting an electronic report.//2008//

/2009/ The SSI report generated by the State Data Exchange was revised to reflect; live, terminated, and terminated-expired children to facilitate timely follow-up and referral.//2009//

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2005	payment source from birth certificate	8.7	7.9	7.9

Notes - 2010
Data is from a file created by the MCH Epdeimiology Program by matching the Electronic Birth Certificate file to the official Birth Certificate file. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files due to missing and unknown insurance type.

Narrative:
The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions Prevention Projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

See Chart #5 'Low Birthweight by Race/Ethnicity' attached to Section III. State Overview for trend data.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000	2004	matching data files	7.6	6.5	6.7

live births					

Notes - 2010
Data estimate for 2004 is from a file created by the MCH Epdeimiology Program by matching the Electronic Birth Certificate file to the Hospital Discharge files and Infant Death Certificate files. Most recent year available is 2003. Calculated rates/percents may not match rates/percents from the official Infant Death Certificate files.

Narrative:
The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions Prevention Projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

See Chart #7 Infant Mortality Rates by Race/Ethnicity' attached to Section III. State Overview for trend data.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	payment source from birth certificate	59.2	84.5	75.1

Notes - 2010
Data is from a file created by the MCH Epdeimiology Program by matching the Electronic Birth Certificate file to the official Birth Certificate file. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files due to missing and unknown insurance type.

Narrative:
The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Initiative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of

direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

/2009/ In order to improve New Jersey's rate of first trimester prenatal care, the DHSS Commissioner convened a Prenatal Care Task Force of stakeholders with representatives from the following organizations: American College of Obstetricians and Gynecologists (ACOG); New Jersey Obstetric and Gynecologic Society (NJOGS); New Jersey Maternal Fetal Medicine Society: New Jersey Academy of Family Physicians; Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN); American College of Nurse Midwives; New Jersey State Nurses Association (NJSNA); March of Dimes, New Jersey Chapter; New Jersey Family Planning Association; New Jersey Hospital Association; Hospital Alliance of New Jersey; New Jersey Primary Care Association; Maternal and Child Health Consortia and The Department of Human Services, Division of Medical Assistance and Health Services.

It is expected that the Task Force would meet for a period not to exceed six months. Background material and data trends along with other references will be provided to the Task Force at the first meeting. The Task Force will submit a report to the Commissioner upon completing their deliberations. //2009//

See Chart #2 'Ist Trimester Prenatal Care Initiation by Race/Ethnicity' attached to Section III. State Overview for trend data.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	payment source from birth certificate	45.9	71	62.2

Notes - 2010

Data is from a file created by the MCH Epdeimiology Program by matching the Electronic Birth Certificate file to the official Birth Certificate file. Most recent year available is 2005. Calculated rates/percents may not match rates/percents from the official Birth Certificate files due to missing and unknown insurance type.

Narrative:

The BIMR, HM,HB, FIMR, FAS, Perinatal Addictions, Post Partum Depression Imitative and HealthStart initiatives are designed to improve birth outcomes for all women through the identification of factors related to LBW, infant mortality and prenatal care and the development of programs to address these factors. The BIMR projects are designated to reduce BIM (SP#3) through public awareness, community education, professional education and the provision of direct health service grants. HM,HB Coalitions are designed to improve early prenatal care utilization (NPM #18) and birth outcomes through extensive community outreach and education activities based on Community Action Team projects based on FIMR (NPM #17) results. The FAS and Perinatal Addictions projects (SP #9) educate providers and consumers on the effects of substance use and abuse on LBW, infant mortality and prenatal care. Through the Post Partum Depression Initiative, education has been provided to over 6,000 healthcare providers. The hospitals and private practitioners are receiving assistance with implementing the new law that requires screening and education at specified intervals during the perinatal period. The HealthStart initiative provides comprehensive health services and maternity and newborn services for high-risk women and infants.

/2009/ In order to improve New Jersey's rate of first trimester prenatal care, the DHSS Commissioner convened a Prenatal Care Task Force of stakeholders with representatives from the following organizations: American College of Obstetricians and Gynecologists (ACOG); New Jersey Obstetric and Gynecologic Society (NJOGS); New Jersey Maternal Fetal Medicine Society: New Jersey Academy of Family Physicians; Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN); American College of Nurse Midwives; New Jersey State Nurses Association (NJSNA); March of Dimes, New Jersey Chapter; New Jersey Family Planning Association; New Jersey Hospital Association; Hospital Alliance of New Jersey; New Jersey Primary Care Association; Maternal and Child Health Consortia and The Department of Human Services, Division of Medical Assistance and Health Services.

It is expected that the Task Force would meet for a period not to exceed six months. Background material and data trends along with other references will be provided to the Task Force at the first meeting. The Task Force will submit a report to the Commissioner upon completing their deliberations. //2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	350

Narrative:
The Medicaid Program in New Jersey is located in the Department of Human Services. Pregnant women with incomes below 200% of the Federal Poverty Level are eligible for Medicaid Health Start comprehensive maternity services. The comprehensive services include medical care, case coordination, health education and psychological services. The percent of poverty level for eligibility in the SCHIP Program for infants is 350%.

Income eligibility levels for NJ FamilyCare by child age and family size are available at http://www.njfamilycare.org/pages/whatItCosts.html

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	350

Narrative:
The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Children in families with incomes below 133% of the Federal Poverty Level are eligible for Medicaid.

The percent of poverty level for eligibility in the SCHIP Program for infants and children 1 to 19 is 350%.

Income eligibility levels for NJ FamilyCare by child age and family size are available at http://www.njfamilycare.org/pages/whatItCosts.html

Parents at higher income levels can purchase health insurance for their children at reasonable rates through the NJ FamilyCare ADVANTAGE program administered by Horizon NJ Health if they qualify.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	350

Narrative:
The Medicaid Program and SCHIP Program in New Jersey are located in the Department of Human Services. Pregnant women with incomes below 200% of the Federal Poverty Level are eligible for Medicaid. The comprehensive services include medical care, case coordination, health education and psychological services.

The percent of poverty level for eligibility in the SCHIP Program for pregnant women is 350%. Several initiatives including Healthy Mothers/Healthy Babies and Healthy Start promote the early enrollment and full participation in the Medicaid and SCHIP Programs.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
The goals of the State Systems Development Initiative (SSDI) grant within the MCH Epidemiology Program focus on Health Status Indicator (CHSI) #9A for building data capacity in MCH. The first goal of the grant focuses on improving linkages of MCH datasets and the second goal of the grant focuses on improving access to MCH related information. Linking MCH related datasets is important to the needs assessment process for communities and the evaluation of program services. Assuring access of FHS to MCH related datasets is important to improving the reporting of Title V MCH Block Grant Performance/Outcome Measures and to improving the

delivery of services to the MCH population.

Our vital statistics files, Medicaid files and programmatic data files all provide some information about the status of health in the MCH population and the effectiveness of MCH programs. However, no file alone provides the full picture of what happens to pregnant women, infants and children. In order to accurately assess the continuum of events that lead to favorable or unfavorable outcomes, files and information systems should be linked.

MCH Epi has been able to both link records across files and longitudinally across health care related events in a mother's life. A combined dataset was created for the years 1996 through 2003 containing the electronic birth certificate, mother and newborn hospital discharge records, and infant death certificates for all NJ births. Data from this dataset are used to support research projects that focus on welfare reform and immigrant health, foreign-born mothers and issues related to health disparities, and maternal mortality review in New Jersey.

Six years of asthma-related hospital discharge data have been longitudinally linked to create a wealth of information surrounding hospitalizations for children with asthma. This dataset is being used to enhance our asthma surveillance system as well as examine issues related to repeat admissions, and asthma severity.

The MCH Epidemiology Program with CDC funding has also implemented the Pregnancy Risk Assessment Monitoring System (PRAMS) Survey in collaboration with the Bloustein Center for Survey Research at Rutgers University. Additional funding was obtained from the Comprehensive Tobacco Control Program within the NJDHSS to include questions concerning maternal smoking. Data from this survey will be used to identify high-risk pregnancy groups and to target programmatic interventions.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
New Jersey Youth Tobacco Survey	3	No

Notes - 2010

Narrative:
The New Jersey Youth Tobacco Survey (YTS), based on a model developed by CDC, is administered by the Comprehensive Tobacco Control Program. This bi-annual survey is administered to a sample of students in grades seven through twelve.
/2009/ The 2006 YTS report is available at the website - http://www.state.nj.us/health/as/ctcp/documents/2006_njyts_report.pdf. Current cigarette smoking prevalence among high school students fell from 27.6% in 1999 to 15.8% in 2006.//2009//

/2010/ An effective strategy to reduce youth smoking prevalence and consumption is to increase the unit price for tobacco by raising the product's excise tax. According to report from the NJDHSS Comprehensive Tobacco Control Program (http://www.state.nj.us/health/as/ctcp/documents/youth_consumption_of_cigarettes.pdf), the overall decline in youth cigarette consumption in New Jersey reflects, in part, the

effects of large increases in the State's cigarette excise tax. New Jersey increased the cigarette excise tax four times in as many years and currently ranks as one of the highest cigarette excise tax among all US states. Higher cigarette taxes generally reduce smoking prevalence and consumption, while increasing tax revenue.

In addition to price increases, several strategies can achieve a substantial reduction in youth consumption. These include limiting youth access to tobacco, strong community-based programs concentrating on secondhand smoke, mass media campaigns combined with community-wide interventions, and evidence-based school health programs.

However, initiatives to reduce youth smoking must be maintained and accompanied by changes in adult behavior. Policy makers must consider approaches that sustain delayed initiation into adulthood. Comprehensive, effective, and sustainable tobacco-control programs, as well as tobacco cessation programs, are essential to reduce tobacco caused disease, death and disability.

Finally, consistent funding for youth prevention must continue. Despite the considerable success achieved in New Jersey, funding for comprehensive tobacco control continues to be reduced. There is evidence that higher state-level tobacco control funding is associated with lower youth smoking prevalence and cigarette consumption.//2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations.

Since 1999 Maternal Child Health Bureau (MCHB) has included performance plans and performance information in its budget submission. MCHB must submit annual reports to Congress on the actual performance achieved compared to that proposed in the performance plan. This section describes the performance reporting requirements of the Federal-State partnership. Figure 3, "Title V Block Grant Performance Measurement System" on the next page, presents a schematic of a system approach that begins with the needs assessment and identification of priorities and culminates in improved outcomes for the Title V population. After each State establishes a set of priority needs from the five-year statewide needs assessment, programs are designed, assigned resources, and implemented to specifically address these priorities. Specific program activities are described and categorized by the four service levels found in the MCH "pyramid" -- direct health care, enabling, population-based, and infrastructure building services. Program activities, as measured by 18 National performances measures and State performance measures should have a collective contributory effect to positively impact a set of 6 national outcome measures for the Title V population.

B. State Priorities

SP #1. Reduction of Adolescent Risk Taking Behaviors

The Reduction of Adolescent Risk Taking Behaviors relates to NPM #8, 10, 13, 16 and SPM #5, 6 & 10. DHSS currently funds 8 Community Partnerships for Healthy Adolescents (CPHA) in 7 counties. Each grantee has an Adolescent Health Plan to address the priority health issues of its adolescent population and has implemented activities since 2003.

The goal of these Partnerships is for local health departments, community-based organizations, schools, and health care providers to coordinate and collaborate on programs and activities that reduce risk-taking behaviors and promote healthy behaviors among adolescents. Each Partnership's activities are based on a local needs assessment that prioritized the adolescent health issues in that community. DHSS guidelines encourage the Partnerships to address sexual behaviors (unintended pregnancy, and sexually transmitted infections including HIV), injury and violence including bullying and gang prevention, nutrition and physical activity and substance use/abuse.
/2008/ Almost 56,000 adolescents, 10-17 years old, were served in 2006.//2008//
/2009/ There were approximately 75,350 contacts with 10-17 year old adolescents made during 2007. On October 27 Burlington County's Community Partnership for Healthy Adolescents sponsored their Fourth Annual Teen Summit.//2009//
/2010/ There was 85,573 contacts with 10-17 year old adolescents made during 2008. It is anticipated that adolescent funding will be competed in 2009.//2010//

SP #2. Reducing Black Infant Mortality

The Northern NJ MCH Consortium has been funded to serve as the Black Infant Mortality Reduction (BIMR) Resource Center under the BIMR Initiative since 1999. The Center acts as a clearinghouse, providing literature, statistics, and other information on BIMR.

In 2006, a Request for Proposal was released for BIMR projects. This RFP focused on modifying

the behaviors, lifestyle and conditions that affect birth outcomes, by improving and providing quality care during the prenatal and infant period, throughout NJ. Six health service grantees are addressing BIM issues statewide.

/2010/ The Prenatal Care Task Force Report included a recommendation to re-evaluate priority areas for infant mortality reduction funding and then redirect those funds as appropriate. A Request for Proposals is in process for release in the spring. //2010//

/2009/ The agencies and their activities are described as follows:

The Central NJ Maternal Child Health Consortium developed, implemented and sustained an effective model of pre/interconceptional education and perinatal outreach that fully integrates into the system of MCH care in each target cities of Plainfield, Trenton, New Brunswick and Perth Amboy

The Hudson Perinatal Consortium will provide outreach to pregnant and childbearing black females and conduct intensive and individualized education and provide referrals to other social and health care services. The program offers educational sessions on topics related to BIM, stress reduction, positive prenatal practices, good health practices and high-risk behaviors to black women of childbearing ages, their infant and family.

The Newark Department of Health and Human Services has provided prenatal and postnatal healthcare prevention and social service support to Newark black mothers, their infants and their families. The program has provided outreach educational sessions on BIM to all women of childbearing ages, and their families and the community.

The Southern Jersey Family Medical Centers, Inc is a federally qualified health center and HealthStart provider, which provides case management, health education and social services to black pregnant women, their infants and their families. The model for this Center is to provide effective health service delivery and promote community awareness in the target areas of Salem, Burlington and Atlantic County on BIM.

The Northern NJ Maternal Child Health Consortium has established a multi-faceted communication program to reduce the incidence of BIM in their region. The consortium has expanded the current website to Black women's access to information via website and phone line, including a health, education and social services resource directory, called "Providing Education Through Advocacy & Learning Strategies"). The goal of the program is to provide preventive education and increase access to health and social services for black women of childbearing age and their children by creating and distributing culturally appropriate prenatal and postnatal educational materials on the awareness and knowledge of BIM risk factors.

The Regional Perinatal Consortium of Monmouth and Ocean Counties, Inc has provided programs to achieve an increase in awareness of BIM issues in Monmouth and Ocean counties through comprehensive education, social support, outreach and culturally competent case management. These services have focus on black women in an effort to close the gaps in education, healthcare services, health prevention and social services provision that currently exist in their region. Their outreach staff partnered with March of Dimes,, and other organizations to provide educational training and awareness on BIM issues.//2009//

SP #3. Reducing Teen Pregnancy

Teen pregnancy prevention is a state priority for NJ and relates to NPM #8 & SPM #4. Several inter-agency initiatives have been developed to address this priority.

The Advisory Council on Adolescent Pregnancy Prevention was established in 1999 to develop policy proposals, to promote a coordinated and comprehensive approach to the problems of

adolescent pregnancy and parenting, and to promote community input and communication. In 2003, the Council developed a 3 year strategic plan. The WorkFirst Teen Pregnancy Prevention Work Group lead by the DHS has been charged with planning, developing and implementing new initiatives. Youth-to-youth programs and mentoring projects and a Teen Pregnancy Resource Center have been established.

DHS, DOE, the Department of Labor and Workforce Development and the Juvenile Justice Commission have collaborated with NJDHSS on the development of statewide County Collaborative Coalitions relative to teen pregnancy prevention activities. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities and events for Teen Pregnancy Prevention Month (May).

/2010/ Title X, NJ Family planning agencies with 60 clinical sites continue to provide comprehensive reproductive health services to adolescents provided free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.//2010//

SP #4. Increasing Healthy Births

Increasing Healthy Births is a state priority that encompasses NPM #8, 15, 17, 18. Several initiatives address healthy births including Healthy Mothers, Healthy Babies Coalition outreach activities, Healthy Start outreach activities, and Community Action Team projects based on FIMR findings. The Perinatal Addictions Prevention projects seek to educate professionals and consumers of the risks involved with substance use and abuse in the perinatal period. Preconceptual health projects seek to have a healthy mother prior to conception.

/2010/ The Perinatal Addictions Prevention projects provide a broad range of acceptable and effective family planning methods and related preventive health services that include natural family planning methods, infertility services and services for adolescents. Clinics have effective contraceptive methods, breast and cervical cancer screening, nutrition and prevention services that correspond with nationally recognized standards of care, STI and HIV prevention education, testing and referral, adolescent abstinence counseling, and other preventive health services. Aimed at schools and community groups, educational activities focus on primary pregnancy prevention, the program integrates assessment of adolescent risk behavior within routine family planning services.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout NJ to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents. The 11th annual Adolescent Health Institute will be held on November 13, 2009.

Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. A request for applications is under development to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report issued in July 2008. This competitive request for applications seeks to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. //2010//

SP #5. Improving Nutrition and Physical Activity

Improving Nutrition and Physical Activity is a state priority related to SPM # 10 and HSCI #9. DHSS funds 3 Community Partnership for Healthy Adolescents to address this priority.

/2009/ Pedometer projects continue to be a motivating strategy for increasing physical activity in youth.
One of the 3 Community Partnerships has implemented the Atlas/Athena evidence-based model program with male and female athletes. Evaluation is being conducted for the 2007/08 school year and results should be available by June 30, 2008.

DHSS submitted an application in March 2008 in response to a 5 year CDC Funding Opportunity Announcement for a Nutrition, Physical Activity, Obesity NPAO Program. DHSS requested $922,132/year. If approved funding would begin June 2008.//2009//
//2010// DHSS awarded 5 year cooperative agreement in the amount of $802,072.00 (June 2008 - June 2013) for nutrition, physical activity and obesity.//2010//

In 1999, State law established the NJ Council on Fitness and Sports, which is in, but not of, the DHSS. The Council promotes the health and wellness of NJ citizens by developing safe and enjoyable recreational and sports activities and programs. In 2004, DHSS provided funding to 2 professional organizations - the NJ Society for Public Health Education (NJ SOPHE) and the NJ Association for Health, Physical Education, Recreation and Dance (AHPERD) - to support pilot projects implementing recommendations of the Council. It is also funding one community-based organization in Trenton to promote nutrition and physical activity for the Trenton community.
/2007/ In 2005, DHSS provided staff support to the Council to assist with 3 projects. //2007//
/2008/ The Second Annual Leaders' Academy for Healthy Community Development was held on May 18, 2007. //2008//
/2009/ 22 Healthy Community Development mini-grants, in amounts ranging from $2,500 to $10,000 were approved by the Council on Physical Fitness and Sports to assist communities in developing wellness and physical activities, such as walking and biking maps or trails that contribute to a healthy and/or safer community for children and families. //2009//
/2010/ Third Leaders' Academy for Healthy Community Development planned for fall 2009. Mini-grants totally $100,000 to be awarded to communities.//2010//

NJ SOPHE coordinated the NJ Childhood Obesity Roundtable II, held in December 2004, in collaboration with Rutgers State University, the NJ Obesity Group and DHSS. Roundtable recommendations/next steps will be shared with the recently legislated NJ Obesity Prevention Task Force. The NJ Obesity Prevention Task Force is a 27 member, Governor-appointed Task Force charged with the responsibility to study, evaluate and develop recommendations and specific actionable measures to support and enhance obesity prevention among NJ residents, particularly children and adolescents.

NJ AHPERD has made pedometer school kits available to elementary and high schools. In addition, 3 bike safety programs were held with one recreation program for 1st - 3rd graders, 4th - 6th graders and 7th -10th graders.
/2010/ In July 2008 an application was approved for HealthCorps, a project of Dr. Mehmet Oz, to promote healthy lifestyles in three NJ high schools (Newark, Cliffside Park and North Bergen). Funding supports salaries for college graduate youth coordinators who work on site with students. Coordinators are trained in standardized HealthCorps procedures and materials.

DHSS supported PCORE - NJ Pediatric Council on Education and Research, the non-profit arm of NJ AAP for two projects: 1. to develop an EPIC childhood obesity module -- Educating Physicians in the Community and 2. to plan and conduct a childhood obesity conference for health care providers and educators (May 2009). //2010//

SP #6. Decrease Asthma Hospitalizations

The DHSS funds the American Lung Association of MidAltantic (ALAMid), to support the infrastructure of the Pediatric/Adult Asthma Coalition of NJ (PACNJ). PACNJ is organized by the ALAMid and the NJ Thoracic Society. It has developed the "Pathway to Asthma Control in NJ,"

that outlines strategies and initiatives to address the asthma burden. PACNJ maintains 6 task forces including: Quality, Community, Schools, Child Care, Environment, and Evaluation. With the support of staff and resources from PACNJ and its member organizations, the task forces design and implement the various strategies/activities identified in the implementation plan.

/2009/ The Asthma Awareness and Education Program (AAEP) and PACNJ redefined and expanded its scope in addressing asthma statewide, the major goal will be to: improve health outcomes for NJ residents with asthma. This goal will be accomplished through: 1) a delivery of care systems change in the NJ FQHCs; 2) increasing the use of Asthma Treatment Plans; 3) improving provider and consumer knowledge of asthma management; 4) creating a systems change in schools and day care centers to accommodate a healthy environment for children with asthma; 5) reporting work related asthma triggers and providing interventions to prevent the occurrence of asthma-related emergencies in the workplace; 6) creating a system that provides feedback to FQHCs regarding their patients that visit the ED and which triggers follow-up care by the FQHCs for those patients; and 7) implementing public health activities to reduce asthma mortality and morbidity, with particular emphasis on asthma in children and other disproportionately affected populations.
/2010/ Significant accomplishments in the last year are detailed in the section for HSCI #1 (rate of children hospitalized for asthma).//2010//

SP #7. Improving and Integrating Information Systems

The MCH Epidemiology Program and the NJDHSS are all involved in efforts to improve and integrate public health information systems. Activities are related to NPM #1, 9, 12 & HSCI #5, 9A, 9B, & 9C. Examples of improving access to and integration of public health information are discussed in sections specific to the performance measures and health systems capacity indicators.

/2010/ The Electronic Birth Certificate (EBC) System is in the process of being upgraded to a web-based Electronic Birth Registry System (EBRS). The Bureau of Vital Statistics and Registration has involved staff from FHS and the MCH Consortia in the development of an RFP for the EBC upgrade. In addition to improving the timeliness, quality, and security of NJ's birth data, the adoption of a web-based EBRS would also facilitate real-time linkages to other data sets, thus laying the groundwork for the development of an electronic child health registry. //2010//

SP #8. Improving Access to Quality Care for CSHCN

NJ will continue to enhance current efforts to improve access to quality of care for CSHCN, as well as provide additional training opportunities for families, case managers, Part C service coordinators and staff of the Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Care Centers, and Ryan White Part D Family Centered HIV grantees in resources and services to support CSHCN in the community. Training will be provided to promote effective involvement of youth and parents in school to work transition, and medical transition to adulthood for the SSI population.
//2009// The Federation of Child Evaluation Centers (CECs) is meeting and teleconferencing regularly with an emphasis on best practices. The evaluation, diagnosis and treatment of autism is a focus of the CECs. Planning is underway for a statewide training of CEC practitioners in Autism Diagnostic Observation Schedule (ADOS) to ensure consistency in diagnosis and timely reporting of autism. In addition, SCHEIS staff have provided consultation on interagency work groups to facilitate access to care for children, including CSHCN, suspected to have been abused and/or neglected. The Pediatric Council on Research and Education of the NJ Chapter of the AAP, Department of Children and Families (DCF), parent advocacy representatives and a representative from SCHEIS comprised a workgroup charged with educating physicians in their communities (EPIC) and their staffs about child abuse and neglect. Plans to implement the trainings among several pediatric practices are underway.//2009//

/2010/ Through collaboration with and funding provided by the DHS, Division of Developmental Disabilities a statewide Autism Diagnostic Observation Schedule (ADOS) training was held at UMDNJ Medical School on September 18 & 19, 2008. Over 25 practioners were trained in using the ADOS tool. All 11 State CEC's are seeing an increase in the requests for a comprehensive team evaluation with concerns related to autism, ASD and PDD. Wait time to see a neurodevelopmental pediatrician ranges from 4-12 months. //2010//

/2009/ SCHEIS maintains a State funded fee-for-service program to assist eligible families with CSHCN to access medically necessary services such as hearing aids, braces, orthotics, and medications for the treatment of asthma and/or cystic fibrosis, that families can not afford and/or are not covered by their health insurance. Statewide mandatory universal newborn hearing screening initiated in 2002, with registration of children to the BDR and referral to SCHS Case Management and/or the Early Intervention System have resulted in an increase in referrals to the FFS program. As a result of increased demand, the DHS, Division for the Deaf and Hard of Hearing (DDHOH) entered into a letter of agreement with SCHEIS to enhance capacity to serve CSHCN in need of hearing aids. Likewise, this letter of agreement has fostered cross referral of families for services provided by both DHS, DDHOH and SCHEIS.//2009//
/2010/ December 2008 enactment of NJ legislation "Grace's Law" mandates partial coverage for hearing aids (up to $1,000/ear biannually for children age birth-15 years) by fully insured health plans. Approximately 25% of New Jerseyans are enrolled in fully insured plans. Although Grace's Law will provide some families with children in need of amplification with partial assistance, a gap remains for many. SCHEIS is collaborating with the Department of Banking and Insurance and the DHS's DDHOH to develop a tool that will assist parents and providers to understand how Grace's Law may benefit them and how to proceed in the event that their plan doesn't fall under the purview of the law. //2010//

Information, referral, development of an individualized service plan (ISP) and ongoing monitoring to achieve identified needs for CSHCN remains a priority of Family Centered Care grantees. These needs include medical/dental, developmental, rehabilitation, education, socio-economic, and emotional. Parent and professional training on accessing comprehensive services for CSHCN through Medicaid Managed Care, updates on changes in NJ FamilyCare, and access to community based services for CSHCN were conducted in 2004, through quarterly case management meetings, Family Centered HIV programs and collaboration on the development of conferences conducted by community based organizations such as the NJ SSI Alliance, SPAN, and the ARC of NJ. Likewise, Family Centered Care Services staff provides ongoing technical assistance to grantees regarding access to care issues, including how to access appropriate community based providers, and how to coordinate services across intergovernmental agencies and programs.
/2008/ Additional training and updates continued through the SCHS Quarterly Case Management meetings, including topics such as the Children's System of Care Initiative, family support programs, dentistry for CSHCN, transition to adulthood.//2008//
/2009/ Access to health care services and supports continued to be presented through trainings provided at the SCHS Quarterly Case Management meetings including the newest NJ FamilyCare health insurance program "Advantage", autism, hearing screening and diagnosis, SSI, lead, services for children with emotional behavioral disorders and others. SCHEIS representation on the SSI Alliance continued with preliminary planning for the upcoming 8th annual conference. //2009//
/2010/ Technical assistance on access to statewide services and supports for CYSHCN continued to be presented through the SCHS Quarterly Case Management meetings. Recent training included care coordination for CYSHCN enrolled in Medicaid Waiver programs and transition to adulthood.

The 8th Annual NJ Social Security Conference-Improving Service…Improving Self was held in September 2007 with over 200 in attendance. The 9th Annual Conference -

Expanding Capabilities in Challenging Times will be held on October 8, 2009.//2010//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	99.6	100.0	100.0	100.0	100.0
Numerator	111583	110905	110634	112406	108791
Denominator	112051	110905	110634	112406	108791
Data Source					Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2007
Source: Newborn Biochemical Screening Program - The number of initial newborn biochemical screenings as reported by the state's Inborn Errors of Metabolism laboratory.

All newborns with confirmed biochemical disorders receive appropriate follow-up as detailed on Form 6.

See attachment to PM #1 Screens and Confirmed Cases by Individual Disorder, SFY 2007

Final 2007 data will be available in 2009.

Notes - 2006
Source: Newborn Biochemical Screening Program - The number of initial newborn biochemical screenings as reported by the state's Inborn Errors of Metabolism laboratory.

All newborns with confirmed biochemical disorders receive appropriate follow-up as detailed on Form 6.

a. Last Year's Accomplishments
The Newborn Biochemical Screening Follow-up Program, within Special Child Health and Early Intervention Services (SCHEIS) ensures that newborns with abnormal screening results receive timely follow-up testing, care, treatment and management. The goal is to rule in or rule out a

disorder, initiate prompt medical care and maintenance treatment and provide parents, practitioners and consumers with appropriate educational materials within nationally established time lines.

All newborns with confirmed disorders received appropriate follow-up - see attached chart.

Newborns receive mandatory screening for 20 disorders: phenyketonuria, hypothyroidism, galatosemia, the hemoglobinopathies, including sickle cell disease, maple syrup urine disease, cystic fibrosis, biotinidase deficiency, congenital adrenal hyperplasia, medium chain acyl-CoA dehydrogenase deficiency, short chain acyl-CoA dehydrogenase deficiency, long chain acyl-CoA dehydrogenase deficiency, very long chain acyl-CoA dehydrogenase deficiency, citrullinemia, argininosuccinic acidemia, methylmaloonic acidemia, propionic acidemia, glutaric acidemia type I, isovaleric acidemia, 3-hydroxy-3-methylglutaryl CoA lyase deficiency and 3-methylcrotonyl-CoA carboxylase deficiency. The Follow-up Program aggressively follows all presumptively positive results by telephone calls to primary care providers and subspecialists to ensure confirmatory testing and initiation of treatment. Support for treatment services and specialized formula includes 4 regional metabolic centers, 3 cystic fibrosis care centers, 5 pediatric endocrine specialty care centers, 2 biochemical genetics laboratories and 5 sickle cell treatment centers.

By the end of March 2009, the current panel of 20 mandated disorders is expected to be increased to 54 disorders. This expansion is in accordance with the Health Resources and Services Administration (HRSA) and the American College of Medical Genetics (ACMG) 2005 report "Newborn Screening: Toward a Uniform Screening Panel and System" recommendation to screen for a minimum of 29 core disorders and 25 secondary conditions. The decision for the expansion is based on recommendations of the New Jersey Newborn Screening Annual Review Committee (Committee). The Committee is composed of pediatricians, pediatric specialists, nurses, parents, scientists, an ethicist, and other health care professionals. The purpose of this Committee is to assist in the ongoing review of newborn screening policy and activities; the Committee also assists in ensuring that New Jersey's Newborn Screening Program remains current in accordance with advances in medical technology.

In preparation for the expansion of the newborn screening panel, education materials have been prepared for parents and health care professionals. Pediatric specialty consultant groups agreed on using HRSA ACT sheets as a resource for physician information to replace the current physician information sheets at the time of expansion. In order to improve parent information material the program already adopted new brochures, developed as a result of extensive HRSA and AAP funded studies. The brochures, entitled ‘These Tests Could Save Your Baby's Life' are available in English and Spanish and have been distributed to all NJ birthing facilities.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expanded screenings to include 54 newborn biochemical disorders.			X	
2. Tandem mass spectrometry technology has been implemented in the Newborn Screening Laboratory.			X	
3. Regional specialty care centers have been established and supported for affected babies and their families.	X			X
4. Ongoing collaboration with specialists and pediatric primary care providers.				X
5. FHS and Public Health and Environmental Lab staff regularly meet with established specialty consultants.			X	X

6. 6. Newborn Screening Annual Review Committee (NSARC) reconvened to advise Newborn Biochemical Screening Program.				X
7. Physician education initiative, consisting of a series of lectures at “grand rounds”, wed-based CME activities and laminated sheets with NBS management and emergency guidelines.	X			X
8. Improvements in generic NBS parent pamphlets.		X		
9. Follow-up protocols, new parent and physician fact sheets for expanded NBS.		X		
10.				

b. Current Activities
In 2002, SCHEIS began funding for the establishment and provision of specialty services in the areas of genetics/metabolic disorders, pediatric pulmonary and endocrine disorders, and specialty laboratory services.

Testing, reporting and follow-up of the additional screening tests will continue to be directly managed by the State. To address technological changes that have the potential for improving sensitivity, specificity and the scope of newborn screening services, the NSARC will continue to assess, evaluate and make recommendations.

For each of the newborn biochemical disorders, semi-annual meetings continue to be held with the respective consultant groups. The purpose of the consultant meetings is to ensure that testing and follow-up procedures used by the State are reflective of best medical and laboratory practices. Additionally, the medical consultants represent the concerns of families with affected newborns, including such diverse issues as insurance reimbursement, obtaining referrals for appropriate medical care and treatment and identification of other unmet needs.

The NBS software vendor, Neometrics, has provided a major upgrade to the current software and hardware environment. This upgrade will ensure better ability to analyze data and perform queries as requested for research purposes.

c. Plan for the Coming Year
•Expansion of the Newborn Screening Panel: Approval for expansion was granted in March, 2009, by the Commissioner of Health and Senior Services. The final implementation date is expected by the end of March 2009 and is dependent on the Newborn Screening Laboratory which is undergoing new mass spectrometer validations.

•Hiring staff for existing positions: The program is working on getting an exempt from the state wide hiring freeze to fill existing positions.

•The follow-up staff reviewed and prepared the following material regarding new expanded disorders:
oFollow-up Protocol Action Sheets for expanded disorders
oNewborn Screening Information for Parents
oDisorder Information for Health Professionals
oPhysician and Parent Notification Letters
oThese materials were reviewed and approved by the Metabolic Consultant Task Force

•Web-based updates regarding the expansion and newborn screening services will be made once the expansion is finalized.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	59	60	61	62	56
Annual Indicator	57.7	57.7	57.7	55.4	55.4
Numerator					
Denominator					
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	57	58	59	60	61

Notes - 2008
Indicator data comes from the National Survey of CSHCN, a numerator and denominator is not available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

a. Last Year's Accomplishments
Through health service grants with the SCHS Case Management Units, the Statewide Parents Advocacy Network (SPAN), the Parent-to-Parent Network, and the Specialized Pediatric Services providers efforts continued to increase the degree to which the State ensured family participation in the CSHCN's program and policy activities. The SCHS Case Management Units linked families of children with special health care needs to community based services such as the Parent-to-Parent Network linked parents of CSHCN to "veteran" parents of children with similar needs for support, information on the disability, and problem solving. In addition, technical assistance and training was provided to families by these grantees to empower parents and/or youth to participate in decision making.

The SCHS Case Management Units provided information and resources to families with CSHCN, developed nearly 8,100 individualized service plans (ISP's) with families to facilitate their children's access to care, and monitored those plans. Parent input into ISP development was solicited. Over the course of the routine monitoring of clients' needs, families were asked about whether the resources they were referred to were helpful, met their needs and whether they were satisfied with the services they/their children received through Case Management as well as through the referred services. Likewise, families served through SPAN and the Specialized Pediatric Services grantees were periodically solicited for their satisfaction in the services they

received. The data collected was reviewed by those grantees and considered in determining whether services met the needs of clients served and/or whether the provider needed to explore changes in operation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SPAN		X		X
2. Parent-to-Parent Network		X		X
3. Statewide Family Voices chapter		X		X
4. Family Satisfaction Survey to be done by the 21 county case management units.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SCHS Case Management Units continue to provide information and resources to families with CSHCN, develop individualized service plans (ISP's) with families to facilitate their children's access to care, and monitor those plans. Parent input into plan development and revision continues to be solicited. As routine monitoring of clients' needs is conducted, families are asked about their goals and anticipated outcomes for their children's needs and whether they are satisfied with the services they/their children receive.

The SCHS Case Management grantees, SPAN and the Specialized Pediatric Services grantees; Cleft Lip/Palate Craniofacial Centers, Child Evaluation Centers and Tertiary Care Centers continue to conduct sampling of family satisfaction with the clients/families served.

c. Plan for the Coming Year

In addition to continuation of the current activities described above, SCHEIS collaborated with SPAN and the New Jersey Academy of Pediatrics to develop a HRSA State Implementation Grant for Systems of Services. SPAN received notice of award for FY 10 and SCHEIS will participate on the core team. This collaborative effort will focus on the six core outcomes for CYSHCN and their families, including partner with parents in decision making at all levels and satisfaction with the services they receive.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	54	55	56	57	42
Annual Indicator	52	52	52	40.8	40.8
Numerator					
Denominator					
Data Source					CSHCN

					Surevy
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	43	44	45	46	47

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated by the CDC with 2002 state estimates from the SLAITS Survey.

a. Last Year's Accomplishments
SCHEIS continues to provide enabling services to children with special health care needs (CSHCN) in order to ensure a "medical/health home" (National Performance Measure #3). SCHEIS has promoted the concept of a "medical home" as defined by the American Academy of Pediatrics through case management services, collaboration with the Statewide Parent Advocacy Network (SPAN), and support of the Child and Adult Special Services Program providers. In 2005, SCHEIS State staff conducted a statewide review of Individual Service Plans for children receiving Special Child Health Services case management to determine status of insurance and whether a primary care physician was identified. Of the 416 charts sampled, the percentage of children with a reported form of health coverage remained at 96% (approximately 46% Medicaid, 50% private, 4% uninsured.) Those without insurance had been screened for eligibility and/or referred for SSI, NJ KidCare, and/or Medicaid. Also, children without a documented primary care provider had been referred for follow-up through Federally Qualified Health Centers, local health department and/or hospital clinics, as well as referral to pediatricians that may be accepting clients without insurance. This informal survey indicated that the majority of children served through the Case Management Units have access to both health care and a primary care provider; however, access to a medical home remains a challenge for some children. This survey will be repeated and extended to include additional Family Centered Care Service providers.
In 2006, 470 charts of children receiving SCHS Case Management were reviewed for status of health insurance and primary care provider. In comparison with 2005, a slight improvement was noted; 98% of the individual service plans reviewed indicated insurance and a primary care provider with a slight shift in Medicaid vs. insured/uninsured; 42% Medicaid, 51% private insurance and 7% uninsured.

The 2007 chart review of children receiving SCHS Case Management was comparable to 2006; 98% of the individual service plans reviewed indicated insurance and a primary care provider, 44% Medicaid, 49% private insurance and 7% uninsured.

To assist families in accessing the Medicaid managed care system, SCHEIS County Case Managers continue to provide consultation, advocacy, information and referral to access

comprehensive health care coverage. In an effort to assist families of CSHCN in navigating the Medicaid managed care system, a Medicaid Managed Care Alliance was formed in 1999. This Alliance is comprised of parents, advocacy groups, representatives from the DHS Office of Managed Care, NJ FamilyCare, HMO case managers, SCHEIS case managers and others. A brochure entitled "Finding Your Way through Medicaid Managed Care…For Families with Children with Special Needs," was developed through this initiative, and continues to be distributed statewide. In 2004, resources listing both managed care case managers and county case management unit staff were revised and distributed among staff members of both systems. Periodic case conferencing continues as needed. In the Pediatric HIV Family Centered Care Network, each of the Network agencies has entered into linkage agreements with the managed care systems operating within their catchment areas.

In 2004 the CECs organized a formal Federation whose primary goal is to advocate for children with developmental, behavioral and learning disabilities through the promotion of community awareness, collaboration of like organizations, promotion of quality care and education, facilitation of collaborative research and communication with public and private agencies. In 2005, the CEC Federation conducted a Legislative breakfast and poster presentation to increase awareness among NJ Legislators and their aides about the comprehensive services provided to children with special health care needs.

The SCHS County Case Managers will continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. Approximately 12,000 children were newly referred to SCHS Case Management in 2007 All are offered case management/care coordination including the development of Individual Service Plans (ISP) that address assessment of and need for comprehensive health, education, social, and rehabilitative services. Included in the ISPs are enabling services such as transportation, economic assistance, service linkages, resp

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case Management Services		X		
2. Your Voice Counts				X
3. Medicaid Managed Care Alliances				X
4. Subsidized Direct Specialty and Subspecialty Services	X	X		
5. Participation in Medical Assistance Advisory Council		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

SCHEIS continues to provide or subsidize direct specialty and subspecialty services to CSHCN by funding Child and Adult Special Services which includes: 11 Child Evaluation Centers (CEC), 5 Cleft Palate Centers, 3 Tertiary Centers, 6 Genetic Centers, 4 Hemophilia Centers and 5 Sickle Cell Centers. These centers provide a comprehensive array of services with a multidisciplinary approach to assure that CSHCN receive coordinated, ongoing, comprehensive care within a medical home. Services are provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN. Additionally, a special insurance program is available for those individuals with Hemophilia A or B who do not have access to any of the traditional insurance programs.

In collaboration with the Epilepsy Foundation of NJ, SCHEIS staff participated on Project Access, an initiative funded by HRSA, National Initiative for Children's Healthcare Quality, National Epilepsy Foundation, and Jersey Shore Univ. MC. This project targeted awareness across health care systems of needs and services for children with epilepsy/seizure disorder to improve access to a comprehensive medical home. As a result, an epilepsy toolkit was developed for and shared with families and physicians, to facilitate communication and coordination of specialty and primary care among the family, primary provider and neurology.

c. Plan for the Coming Year

The SCHS County Case Managers will continue to provide consultation, advocacy, information and referral to access comprehensive health care coverage. Approximately 12,000 children were newly referred to SCHS Case Management in 2007. All are offered case management/care coordination including the development of Individual Service Plans (ISP) that address assessment of and need for comprehensive health, education, social, and rehabilitative services. Included in the ISPs are enabling services such as transportation, economic assistance, service linkages, respite care, and general support in terms of rights and safeguards. Case managers work with families and physicians to ensure care that is accessible, continuous, comprehensive, family-centered, coordinated, and compassionate. It is anticipated that implementation of the autism registry will result in an increase in referrals of children with autism. Additional trainings in autism diagnosis, treatment and family support for the SCHS Case Managers are anticipated. To facilitate linkage with a medical home, SCHEIS redesigned its statewide brochure in a family friendly question and answer format. The brochure was field tested for cultural competency and translated into Spanish.

SCHEIS will continue to provide or subsidize direct specialty and subspecialty services to CSHCN by funding: 11 CECs including 6 FAS sites, 5 Cleft Palate Centers, 3 Tertiary Centers, 6 Genetic Centers, 4 Hemophilia Centers and 5 Sickle Cell Centers. The CEC Federation will continue to promote community based comprehensive services for CSHCN and the availability of those services in NJ. Services will be provided to the uninsured and underinsured utilizing a sliding-fee-scale and include a comprehensive array of services consistent with the multidisciplinary team approach to advocate for CSHCN. No child is denied service due to the inability to pay. It is anticipated that implementation of the autism registry will result in an increase in referrals of children suspected to have autism.

In addition, an intergovernmental transfer from DHS to manage a $500,000 grant to UMDNJ Medical School was received to increase capacity for their Autism Center. There is collaboration with the NJ Council for Medical Research and Treatment of Autism which also provides funding to UMNDJ. Joint site visits have been made to review charts, access to clinical services and coordination across systems with the CEC and referral to community based services and follow-up services.

SCHS, Case Management State Staff and the Monmouth County Case Management Unit Coordinator have been providing technical assistance and support to the NJ AAP's Pediatric Council on Research and Education (PCORE) efforts to begin a pilot medical home program in Monmouth County. The program will provide technical assistance to 8 pediatric practices in setting up and sustaining a medical home for their clients, commencing with a county wide medical home summit in April 2009.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	63	63	64	64	61
Annual Indicator	62.1	62.1	62.1	59.9	59.9
Numerator					
Denominator					
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	62	63	64	65	66

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

a. Last Year's Accomplishments
SCHEIS continues to ensure accessibility of Children with Special Health Care Needs (CSHCN) to primary and specialty care through the support of specialized pediatric services and County Case Management Units. However, challenges remain in access to care for uninsured CSHCN, with a slight increase in the reported number of uninsured served by CSHCN programs in 2004. Health insurance data extrapolated from the combined CSHCN programs in 2005 indicated no significant change in the CSHCN identified as uninsured (should have read un-insured approximately 4%), 4% of the nearly 38,800 CSHCN in 2005 versus 4.5% of the 42,000 CSHCN served in 2004. The rate of uninsured continued fairly consistently at 4% in 2006. Nearly 4% of CSHCN reported Medicaid eligibility in 2006, The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program. The 2006 report of total CSHCN served was 38,500, and remained nearly level as compared to 2005 (38,800.) Likewise, no significant change was noted in CSHCN self-identified as insured, nearly 49% in 2006. The 2007 data for total CSHCN served was comparable to 2006, at 38,500 and 48% insured.

2008 reporting for CYSHCN in SCHS Case Management indicated significant shifts in insurance status as compared to 2007; families reporting private insurance dropped 1% (47 % in 2007 versus 46% in 2008), CYSHCN on Medicaid and/or Medicaid Waivers increased 4% (44% in 2007 versus 48% in 2008), uninsured remained stable at 2% however the reporting of unknown insurance status improved by 2%.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. County Case Management		X		
2. Subsidized Direct Specialty and Subspecialty Services	X	X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Despite challenges created by a rapidly changing health care environment, SCHEIS has continued to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to children with special health care needs (CSHCN). The CSHCN programs in New Jersey have traditionally provided and/or financed specialty and subspecialty care services through a network of specialty clinics. More emphasis continues to be placed on providing care coordination through the County Case Management Units. With many families transitioning to managed care, and more parents losing their jobs and health coverage, the care coordination services of County Case Management Units are now even more important to ensure comprehensive care due to potential restrictions created by utilization review, referral requirements, and closed panel networks and the high cost of COBRA. Anecdotal experience this past year has proven the benefits of the County Case Management Units who have assisted families in navigating the complicated managed care system to obtain necessary services.

c. Plan for the Coming Year

SCHEIS will continue to ensure the availability of specialty and subspecialty services, including care coordination, not otherwise accessible to CSHCN. SCHEIS will continue to collaborate with other Medicaid Managed Care and Medicaid Assistance Advisory Council (MAAC) members to facilitate access to specialty and subspecialty services. Training will continue regarding changes in Medicaid programs including the newly released Advantage program for uninsured children with family incomes above 350% FPL. The County Case Management Units will continue to provide care coordination at no expense to families and to assist in referring families to resources such as Medicaid, New Jersey FamilyCare, the Catastrophic Illness in Children Relief Fund program, and the Charity Care program.

The County Case Management Units will continue to monitor clients' needs including family and child's insurance status and provide referral to NJ FamilyCare, Medicaid and/or Advantage as warranted. State staff will plan on additional trainings for Case Management Unit staff on SSI, unemployment benefits, COBRA, and other supports for uninsured families of CYSHCN and those at risk for losing employer sponsored benefits.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	77	78	79	80	88
Annual Indicator	75.9	75.9	75.9	88	88
Numerator					
Denominator					
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	91	91	91

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

a. Last Year's Accomplishments
In 2005 SCHEIS and the Statewide Parent Advocacy Network (SPAN) continued collaborative efforts to ensure access to care for CSHCN. Family input is on services through participation at Family Centered Care Services provider meetings, both as attendees and presenters; including transition, advocacy and support. In addition, 2006 SCHS Case Management Unit family satisfaction survey respondents indicated that the majority of respondents were satisfied or very satisfied with the availability of their case manager, child and family's needs were being addressed in a culturally competent manner and their confidentiality was maintained.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Statewide Parents Advocacy Network			X	
2. Parent-to-Parent Network			X	
3. Family Voices parent group			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaboration between the Statewide Parent Advocacy Network (SPAN) and SCHEIS, which began 12 years ago, has enhanced the provision of accessible family-centered care. SPAN is the only federally funded parent training and information center for parents of children with disabilities and special health care needs in New Jersey. During 2008, 16 Case Management Units housed 16 SPAN Resource Parents who provided technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. The Resource Parents documented nearly 6800 contacts with families and professionals during that time. In addition, SCHEIS provided funding in 2002 for a project enabling volunteer parents trained through SPAN to provide statewide coverage for the New Jersey Parent-to-Parent Program. As another statewide initiative, SCHEIS continues to collaborate and partially support a Family Voices chapter, whose mission is to provide parents with training in family leadership, policy making, and advocacy in health care.

In addition, the Case Management units have collaborated and developed a standardized Family Satisfaction Survey intended to assess the family's experience with case management services, responsiveness to needs and effectiveness of referrals. The Family Satisfactions Survey was piloted and will become standardized for use statewide in 2006.

c. Plan for the Coming Year

Collaboration between the SPAN and SCHEIS will continue to enhance the provision of accessible family-centered care. SPAN Resource Parents will provide technical assistance and support to families and/or staff in the areas of specific disabilities and education, as well as transition to preschool and adulthood issues through Project Care. SCHEIS will continue to collaborate and partially support a Family Voices chapter.

Contingent upon the availability of funding, an additional five Parent Resource Specialists have been trained and will be housed this spring at five southern counties; Cape May, Cumberland, Burlington, Salem and Gloucester. Funding to support this expansion of family support resources at the SCHS Case Management Units was identified by SPAN through a parent training grant. This collaborative initiative will bring the total number of case management units with onsite part-time family support up to 15 counties.

The 2005 SCHS Case Management Family Satisfaction Survey was conducted by mail. Families were randomly surveyed, and 437 out of 715 (61%) indicated that overall families were satisfied with their case management services; 89% would recommend the service to others, and 77% received a clear explanation of services for their CSHCN. Likewise, most respondents indicated that they were satisfied or very satisfied with: resources, availability of case manager, their child's needs were addressed, family's concerns were addressed, services were culturally sensitive and confidentiality was maintained. A 2007 family satisfaction survey is underway. SCHEIS will continue to participate in quarterly MAAC meetings to facilitate access to specialty services for CSHCN, as well as the DHS Aged, Blind and Disabled sub-group targeting the transition from fee-for-service Medicaid to Medicaid Managed Care.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	7	8	10	12	40

Annual Indicator	5.8	5.8	5.8	37.9	37.9
Numerator					
Denominator					
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	41	42	43	44	45

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. A numerator and denominator are not available.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with 2002 state estimates from the SLAITS Survey.

a. Last Year's Accomplishments
In addition to ongoing transition to adulthood information, referral, counseling and support provided by Family Centered Care grantee's case managers, SPAN Resource Specialists, social work and medical staff, multiple transition trainings were conducted in 2005, through parent and provider organization collaborations. As members of the ARC of New Jersey's Mainstreaming Medical Care Executive Committee, Family Centered Care staff assisted in developing and conducting a training for parents of CSHCN at the ARC of New Jersey's 16th Annual Mainstreaming Medical Care Conference. Presentation topics included accessing care for the developmentally disabled, dental care, and medications for dual eligibles. Representation continued on the ARC's Mainstreaming Medical Care Advisory Board, and the 17th Annual Conference included break-out sessions on the importance of the prevention of lead exposure, screening, treatment, and follow-up for the lead burdened child as well as community based supports. Likewise, parent and professional training was provided through collaboration with the NJ SSI Alliance, an association of SSI stakeholders including consumers, State agencies, and advocacy groups. Approximately 250 attendees participated in the 7th Annual NJ SSI Alliance Conference. Targeting SSI and SSDI enrollees, the 2005 conference included topics such as how to access SSI benefits, medical and school to work transition, Ticket to Work, PASS, NJ Workability and other benefits available to persons eligible for Medicaid and/or Medicare. Planning for the 8th Annual NJ SSI Alliance Conference began and will focus on transition.

Enabling transition to adulthood for CSHCN is approached through several ongoing collaborative efforts between Family Centered Care Services staff, intergovernmental agencies, and parent advocacy groups. Since 1993, Family Centered Care Services (FCCS) staff collaborated with staff from the Social Security Administration, New Jersey Epilepsy Foundation, Department of

Labor Vocational Rehabilitation and Disability Determination units, Department of Human Services Medicaid and Mental Health units, advocacy groups such as SPAN, Community Health Law Project, Family Voices New Jersey, Legal Services of New Jersey and others, on the development of the New Jersey SSI Alliance. The SSI Alliance meets quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and supports, which are invaluable to youth transitioning to adulthood. In addition, FCCS staff participated with the Epilepsy Foundation of NJ in the development of a Toolkit on Epilepsy which included information to assist youth with Epilepsy to access resources.

In addition, a draft transition to adulthood packet has been developed through a pilot project conducted in collaboration with SPAN and the Essex Healthcare Foundation, at the Essex County SCHS case management unit. The packet targets families with CSHCN and includes information on Department of Education Section 504 basic rights, Individual Health Plan development, SPAN, SCHS, and a description of the New Jersey Catastrophic Illness in Children Relief Fund financial assistance program. Distribution of the packet to CSHCN age 13 and older served through the county case management units is underway. Likewise, during 2004, a statewide training about transition to adulthood was conducted by SPAN for parents of CSHCN, and staff of the SCHS Case Management Units, Child Evaluation Centers, Cleft Lip/Palate Centers, Tertiary Centers, Family Centered HIV Centers, and HMO case managers.

In 2005, a Transition to Adulthood committee was convened by State SCHEIS staff including representation from the SCHS Case Management Units and SPAN to expand transition packet. Plans to standardize a statewide transition resource tool for SCHS Case Management Units, including the Roadmap for Transition is targeted for development in 2006, followed by a statewide training on transition.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition to adulthood needs assessment		X		
2. Transition planning for CSHCN in SCHS Case Management		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling transition to adulthood for CSHCN continues through several ongoing collaborative efforts between Family Centered Care Services staff, intergovernmental agencies, and parent advocacy groups. The SSI Alliance meets quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and supports, which are invaluable to youth transitioning to adulthood. Distribution of the transition to adulthood packet to CSHCN age 13 and older served through the county case management units is underway. Plans to standardize a statewide transition resource tool for SCHS Case Management Units, including the Roadmap for Transition will be followed by a statewide training on transition.

SCHS County Case Management Units continue to monitor transition to adulthood planning with CYSHCN and distribute county specific resources and/or the Transition to Adulthood CD. Elizabeth Collins of the Specialized Pediatric Services represents the Assistant Commissioner's

Office on the State Special Education Advisory Council as a Resource Representative. She sits on the Transition Committee and most recently the focus has been on the teaching of social skills in preparation for career, education and life skills. The committee has been reviewing the New Jersey's Core Curriculum Content Standards and how to incorporate the necessary skills into the standards. Included is the need for a medical home for the transitioning youth.

c. Plan for the Coming Year

The SSI Alliance will continue to meet quarterly to share information, promote awareness and provide training and technical assistance related to SSI benefits and support, which are invaluable to youth transitioning to adulthood. Plans for the upcoming annual NJ SSI Alliance conference are being developed for the next year. Transition to adulthood packets with state, local and federal resources will continue to be disseminated to CSHCN through their SCHS CMU at or about age 13.

As a result of a collaboration between Title V, the Academy of Pediatrics, SPAN and the Epilepsy Foundation of New Jersey (EFNJ) a statewide needs assessment targeting transition to adulthood for children and youth with special health care needs is proposed for 2005. Rutgers University researchers will be contracted to analyze New Jersey specific SLAITS data, and collaborate SPAN and/or EFNJ's efforts to conduct focus groups, and survey health care providers to determine transition to adulthood needs for New Jersey youth.

A transition to adulthood needs assessment was conducted by Rutgers University which included a New Jersey specific analysis of 2000-2002 SLAIT data, pediatric specialist and adult medical provider interviews and interviews of families of children with special needs aged 16-26 years with one of the following diagnoses: Cleft Palate, Spina Bifida, Diabetes or Sickle Cell. The needs assessment was intended to determine a better understanding of the factors and issues that facilitated successful transitions as well as those barriers which prohibit the transition process. Although the sample sizes were small, the findings suggested several resources that may be helpful in facilitating transition, including family supports in the form of educational resources, workshops and tools such as lists of providers. These families would also benefit from more assistance from social service providers about their specific adult services and involvement of their pediatricians and adult doctors throughout the transition process. Physicians would also benefit from more assistance from specific providers and information on special needs, such as having a case manager to help adolescents moving toward adulthood, parent support resources and creating a "transition time."

The 9th Annual Conference -Expanding Capabilities in Challenging Times will be held on October 8, 2009. In addition, SCHS Case Management Units will continue to monitor transition goals and provide resources and support.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	76	79	82	83	83
Annual Indicator	82.7	78.2	78.8	82.3	82.3
Numerator					
Denominator					
Data Source					NIS, CDC

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	84	84	85	85	86

Notes - 2008
Data from the 2007 National Immunization Survey is entered as provisional data for 2008.

Final 2008 data will be available from the CDC in 2010.

Notes - 2007
Data is from the National Immunization Survey, (Q1/2007-Q4/2007) from the CDC. The data is reported as 82.3 ± 6.2
http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2007.htm
No numerators or denominators are available.

Notes - 2006
Data is from the National Immunization Survey at the CDC. The data is reported as 78.8 ± 6.1
http://www.cdc.gov/vaccines/stats-surv/nis/tables/06/tab02_antigen_iap.xls
No numerators or denominators are available.

a. Last Year's Accomplishments
New Jersey has achieved a 82.3% age appropriate immunization rate in 2007, according to the CDC National Immunization Program. To address age appropriate immunizations (National Performance Measure #7), the Immunization Program in the Division of Communicable Diseases continues to support immunization at clinics in local health departments, Federally Qualified Health Centers (FQHCs), and other pediatric clinics. The State's Vaccines for Children Program became available to private practitioners for the first time in 1999. The Division of Family Health Services (FHS) continues to work collaboratively with the Immunization Program to promote age appropriate immunizations.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Immunization Program in Communicable Disease				X
2. NJIIS web-based registry			X	
3. NJ Vaccines for Children Program			X	
4. Local health department child health conferences		X		
5. Universal Child Health Record for all children in child care			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The NJDHSS began the "rolling-out" of a re-designed, web based, statewide universal childhood Immunization Registry in April 2003, through a series of introductory efforts sponsored by the

seven regional maternal child health consortia. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate. Interfaces with private insurance carriers have been completed and they will be able to populate the registry as well via physicians accounting entries once the enabling legislation completes its way through the State Legislature. A new, nationally sponsored program, NICHQ, has been joined by DHSS and the New Jersey Chapter of the American Academy of Pediatrics to facilitate the introduction of the Immunization Registry into practice sites in targeted areas of particular need. Similar efforts are on going with the Academy of Family Practice of New Jersey as well. The Registry interfaces with the programmatic requirements of WIC and Medicaid.

NJDHSS revised the administrative rules (N.J.A.C. 8:57-4) with substantive changes to include the requirement of four new vaccines (Diphtheria and tetanus toxoids and pertussis vaccine, Pneumococcal conjugate vaccine, Influenza vaccine, and Meningococcal vaccine) for school, preschool and licensed child-care center attendance beginning in September 2008. A summary of the changes is available at http://www.state.nj.us/health/cd/documents/vaccine_qa.pdf.

c. Plan for the Coming Year
FHS continues to work collaboratively with the Immunization Program to promote age appropriate immunizations. All newborn infants in New Jersey are automatically entered into the system at birth via the Electronic Birth Certificate to permit tracking of population-based immunization rates and to promote the completion of immunization schedules through record sharing. Interfaces with private insurance carriers and physician offices will also contribute to populating the registry.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	16	12.5	12.4	12.3	12.2
Annual Indicator	12.5	12.3	12.1	12.4	9.7
Numerator	2216	2216	2184	2233	1755
Denominator	176780	179456	180484	180103	180103
Data Source					BC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	12	11.8	11.6	11.4	11.2

Notes - 2008
Source: Provisional Electronic Birth Certificate file as of 5/19/2009.
Denominator from http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ07single.xls
Final 2008 data will be available in 2010.

Notes - 2007
Source: Electronic Birth Certificate file as of 5/19/2009.
Denominator from http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ07single.xls

Notes - 2006
Source: Electronic Birth Certificate file as of 5/19/2009.
Denominator from http://lwd.dol.state.nj.us/labor/lpa/dmograph/est/NJ07single.xls

a. Last Year's Accomplishments
Sixteen family planning agencies with 60 clinical sites provided comprehensive reproductive health services to more than 35,000 adolescents to assist the Title V program in meeting National Performance Measure # 8, reduction of births to teens 15 - 17 years of age. Clinical services include physical assessment, laboratory testing and individual education and counseling for all FDA approved contraceptive methods.

Family planning agencies also provided community education and outreach to the adolescent population. Aimed at schools and community groups, educational activities that deal with decision-making, value clarification and establishing linkages with youth-serving agencies were encouraged. Educational efforts are directed toward primary pregnancy prevention activities that encouraging family communication, promoting self-esteem, postponing sexual activity and promoting effective contraception. All family planning agencies have implemented an enhanced service package, which for Medicaid beneficiaries is a reimbursable service. The program integrates assessment of adolescent risk behavior within routine family planning services. Through direct individual preventive education or through referral, the program promotes behaviors of healthy lifestyle, injury prevention, drug, alcohol and tobacco prevention, as well as sexually transmitted disease (STD) and pregnancy prevention.

MCH resources also continue to support a Young Fathers Program in Newark. The Program provides counseling services to young men between the ages of 15-23 years to enhance their social and emotional functioning, increase their financial independence, and promote responsible behavior.

The Family Planning coordinator serves on the Region II Male Advisory Committee (MAC). The document "Guidelines for Male Sexual and Reproductive Health Services," a tool for family planning providers, was compiled in English and translated into Spanish and then distributed to all Region II Family Planning agencies. The MAC recommends that the guide be used as a tool by an agency to develop an organizing structure, outlining the male services to be included in their program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family Planning Agencies providing comprehensive reproductive services.	X		X	
2. Collaborate with Dept. of Human Services Adolescent Pregnancy Prevention Program.				X
3. Adolescent Pregnancy Prevention Advisory Council				X
4. Community Partnership for Healthy Adolescents Grants				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title X, NJ Family Planning agencies with 60 clinical sites continue to provide comprehensive reproductive health services to adolescents free of charge or at a nominal fee. They assure on-going high quality family planning and related preventive health services that will improve the overall health of individuals, with priority for services to individuals from low-income families.

In addressing NPM # 8 Teen Birth Rate, collaboration with the DHS, the DOE, the Department of Labor and the Juvenile Justice Commission relative to teen pregnancy prevention activities continues to focus on the promotion and development of statewide County Collaborative Coalitions. Regional forums continue to be held which bring together stakeholders from a variety of agencies and organizations to envision, plan and implement local adolescent pregnancy prevention activities for Teen Pregnancy Prevention Month (May).

Presently, this interdepartmental workgroup is drafting a long-range strategic plan, which supports the goals and objectives of sustained adolescent pregnancy prevention services and strategies. Also, intradepartmental planning is underway for the 8th Annual Day of Learning, which has recently broadened in scope to include peer leadership training on teen pregnancy and HIV/STD prevention. This program is now referred to as the Teen Prevention and Education Program, and a "Day of Learning" has been held annually in May to highlight pregnancy prevention month.

c. Plan for the Coming Year

Family Planning agencies with 60 clinical sites will continue to provide comprehensive reproductive health services to over 131,756 clients each year to assist the Title V program to meet the National Performance Measure #8, reduction of birth to teens 15 -- 17 years of age. MCH resources also continue to support a Young Fathers Program in Newark.

Annually, the interdepartmental workgroup co-sponsors an Adolescent Health Institute in November. This one-day program was established for the purpose of bringing together adolescent stakeholders from throughout the state who are given an opportunity to participate in a forum that will provide up-to-date information and resources as they pertain to the many issues and challenges facing NJ youth.

The Family Planning Program hosts an annual Adolescent Health Institute to bring together adolescent stakeholders from throughout New Jersey to foster networking and collaboration and to provide an opportunity to focus on new information and resources as they pertain to the many issues facing adolescents. Nursing contact hours and certificates of professional development are awarded. The 11th annual Adolescent Health Institute will be held on Friday, November 13, 2009.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	43	44	44	45	45
Annual Indicator	40	40	42	42	46
Numerator					
Denominator					
Data Source					Dental Sealant Survey

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	47	47	48

Notes - 2008
The 2008-2009 oral health survey of third grade children in a sample of elementary schools found that 46% of students had a dental sealant on a permanent molar back tooth.

Notes - 2007
During the 2006-2007 dental sealant survey, two additional parent/guardian recall questions were asked as follows: "Has your child ever had a cavity?" Data revealed that 52% of third grade students had a cavity during their lifetime. The other question asked, "Did your child have a dental checkup in the last year?" Data revealed that 87% of third grade students had a dental checkup during the last year.

Notes - 2006
2006 data is based on the NJ Dental Sealant Survey conducted during the 2006-2007 school year which gave a provisional statewide estimate of 42% of third grade students with sealants.

a. Last Year's Accomplishments
In the area of oral/dental health, support continues for two regional programs that employ dental hygienists who act as the Regional Oral Health Coordinators providing oral health education to school students through a variety of age appropriate teaching programs. During the 2007-2008 school year over 25,549 students participated in "Save Our Smiles", the weekly fluoride mouth rinse program. Approximately 75,000 children received some type of age appropriate oral health education in a variety of school and community settings. A number of collaborative initiatives were developed that address good oral hygiene practices in children and pregnant women and include collaboration with federally qualified health centers and homeless shelters.

A dental sealant survey of third grade children in a sample of elementary schools was conducted during the 2006-2007 school year and the survey found that statewide 42% of third grade students had a dental sealant. Data elicited from the 2008-2009 oral health survey found that 46% of students had a dental sealant on a permanent molar back tooth. The data is consistent from surveys conducted during previous school years, however it does note a slight increase in sealant usage.

Beginning in 2007, two additional questions were asked on the parent/guardian recall survey pertaining to other dental/oral health issues. In 2009, a total of four additional questions were asked on the survey. See attached chart with survey results. Data from the 2007 survey revealed that 52% of third grade students had a cavity during their lifetime. The other question asked, "Did your child have a dental checkup in the last year?" Data revealed that 87% of third grade students had a dental checkup during the last year. During the 2008-2009 school year, a total of five parent/guardian recall questions were asked. Data revealed that 51% of the children had a cavity or filling during their lifetime and 91% of the children had a dental check-up within the last year.
An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Federally Qualified Health Center (FQHC) Expansion	X			X
2. Physician/Dentist Loan Redemption Program				X
3. Regional Oral Health Promotion Programs			X	X
4. Give Kids a Smile Day			X	X
5. ”Save Our Smiles”, Fluoride Mouthrinse Program			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Federally Qualified Health Centers (FQHC) Expansion program continues to provide financial support of dental health services. The FQHC Expansion program will continue to provide financial support of dental health services and the Physician/Dentist Loan Redemption Program will work to place more dentists in underserved areas of the State. The state supported FQHC capacity building effort will work to increase access to dental services.

c. Plan for the Coming Year

To improve pediatric oral/dental health, the "Cavity Free Kids" program, the "Save Our Smiles" program and other age appropriate oral health programs will continue to provide oral health education to school age students. Collaboration continues with the New Jersey Dental School and the New Jersey Dental Association to promote "Give Kids a Smile Day" which was held in February, 2009. In addition, The NJ Homeless Shelter Collaboration Project between the Children's Oral Health Program and the NJ Dental Hygiene Association is planned for the coming year and will target 5 shelters in the State and provide oral health education and hygiene instruction to children. The Pregnancy and Oral Health Initiative Collaboration Project between the Children's Oral Health Program and a federally qualified health center is in the planning and development stage and will take place next year. An Oral Hygiene Instruction Initiative between the Children's Oral Health Program and Burlington County Community College Dental Hygiene students will again take place in 2010.

In support of the ECCS grant goals and objectives for early childhood systems building, a collaboration with the Head Start-State Collaboration Project, a federal grant was submitted and awarded to convene an Early Childhood Oral Health Forum. The forum was held May 10, 2007 to address the oral health needs of underserved children in Head Start, Early Head Start, and children in child care settings. Approximately 75 health and oral health participants in and provided input for the development of an oral health action plan for New Jersey's children from birth to six.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	1.7	1.6	1.6	1.5	1.3
Annual Indicator	1.6	1.3	1.3	1.2	1.2

Numerator	28	23	23	21	21
Denominator	1788012	1737386	1737386	1709703	1709703
Data Source					CDC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	1.2	1.2	1.2	1.1	1.1

Notes - 2008
Most recent data available (2006) from the CDC is provided as an estimate for 2008
Data source - CDC National Center for Injury Prevention and Control
http://www.cdc.gov/ncipc/wisqars/

Notes - 2007
Most recent data available (2006) from the CDC is provided as an estimate for 2007
Data source - CDC National Center for Injury Prevention and Control
http://www.cdc.gov/ncipc/wisqars/

Notes - 2006
Data source - CDC National Center for Injury Prevention and Control
http://www.cdc.gov/ncipc/wisqars/
All Races, Both Sexes, Ages 0 to 14
ICD-10 Codes: V02-V04,V09.0,V09.2,V12-V14,V19.0-V19.2,V19.4 V19.6,V20-V79, V80.3-V80.5,V81.0-V81.1,V82.0-V82.1,V83-V86,V87.0-V87.8, V88.0-V88.8,V89.0,V89.2, X82,Y03,Y32

a. Last Year's Accomplishments
The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes has declined since 1997 both in New Jersey and in the United States.

In 2008 the NJDHSS Office of Injury Surveillance and Prevention (OISP) convened a panel of injury prevention experts to provide recommendations in key injury areas which included motor vehicle crashes and unintentional childhood injuries. Recommendations are included in the Aug 2008 report - Preventing Injury in New Jersey: Priorities for Action.

The main factors that contribute to motor vehicle occupant fatalities in NJ are speed, alcohol, and failure to use restraint options including infant seats, booster seats, and seatbelts. Proper use of occupant restraints plays an important role in reducing fatalities and serious injuries among children in the event of a crash. Seatbelt use in NJ is above the national average, and 2007 data from the NJ Division of Highway Traffic Safety estimated the usage rate at over 91%. A recent "Click it or Ticket" mobilization effort combining education and enforcement resulted in an increase in seat belt use among motorists.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Child Care Initiative safety focus			X	

2. Childhood Lead Poisoning Prevention Project's safety focus				X
3. NJDHSS Office of Injury Surveillance and Prevention report - Preventing Injury in New Jersey: Priorities for Action			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Although not specifically focused on deaths due to motor vehicle crashes, progress has been made on unintentional injury prevention activities. The Childhood Lead Poisoning Prevention Projects, in addition to providing lead-focused case management, instruct families in child safety including use of infant car seats and child restraint systems. Safety at home and in the child care center is one of the major focuses of the Healthy Child Care New Jersey Initiative.

c. Plan for the Coming Year

The Healthy Child Care New Jersey Initiative will continue to emphasize safety at home and in the child care center, and has collaborated with the state's Emergency Medical Services for Children program to develop a training curriculum entitled "Anticipating the Unexpected in Child Care Settings". This curriculum has been provided to child care providers in a variety of venues, including the inclusion of related articles in the quarterly Early Childhood Health Link newsletter.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			30	42	46
Annual Indicator		29	37.3	37.3	37.3
Numerator					
Denominator					
Data Source					NIS, CDC.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	38	39	40	41	42

Notes - 2008

2005 data entered for provisional 2008 data.
Source: National Immunization Survey, CDC.

Final 2008 data may be available from the CDC in 2011.

Notes - 2007
Source: National Immunization Survey, 2005 Births, Centers for Disease Control and Prevention, US Department of Health and Human Services
http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm

New Jersey 37.3±7.4

Final 2007 data may be available from the CDC in 2010.

Notes - 2006
Source: National Immunization Survey, 2005 Births, Centers for Disease Control and Prevention, US Department of Health and Human Services
http://www.cdc.gov/breastfeeding/data/NIS_data/2005/state_any.htm

New Jersey 37.3±7.4

Final 2006 data may be available from the CDC in 2009.

a. Last Year's Accomplishments
In Healthy New Jersey 2010, there are two objectives for breastfeeding: 1) to increase the proportion of mothers who breastfeed their babies at hospital discharge to at least 75.0 percent and 2) to increase the proportion of breastfed infants who are breastfed exclusively at hospital discharge to 90.0 percent. The national breastfeeding objectives are for 75% of mothers to breastfeed in the early postpartum period, for 50% of new mothers to continue breastfeeding until their infants are six months old, and for 25% to breastfeed until one year.

Despite the overwhelming evidence supporting the numerous benefits of and recommendations for exclusive breastfeeding, exclusive breastfeeding rates in the 24 hours prior to hospital discharge in New Jersey continued to decline in 2007 (See Chart 9 attached to Table of Contents), while any breastfeeding (both breastfeeding and formula feeding) rates continued to increase, yielding an overall increase in breastfeeding initiation rates. In 2007, exclusive breastfeeding at hospital discharge statewide was 35.7% while any breastfeeding (exclusive and combination feeding) was 70.5%.

Breastfeeding rates on discharge varied with the minority composition of mothers. Asian non-Hispanic women were most likely to breastfeed (85.7%) while Black non-Hispanic women were least likely to breastfeed (53.3%). White non-Hispanic and Hispanic women initiated breastfeeding at 69.9% and 75.2% respectively.

The exclusive rates were 47.5% for White non-Hispanic women, 36.1% for Asian non-Hispanic women, 22.8% for Hispanic women, and 21.0% for Black non-Hispanic women. Further examination of the disparity in these rates will require information of locally available breastfeeding promotional activities, protocols, and the cultural appropriateness of those services.

Closer collaboration between Maternal, Child, and Community Health Services (MCCH) and WIC Services (WIC) has begun. Both programs have an interest in breastfeeding protection, promotion and support and have similar constituencies. The programs looked at how breastfeeding is addressed in delivery hospitals by medical staff, clerks, and educators. The CDC Guide to Breastfeeding Interventions was sent to all the delivery hospitals in the State.

In 2008 FHS developed an annual report card Breastfeeding and New Jersey Maternity Hospitals (posted at NJ.gov/health/fhs/professional/breastfeeding_report.shtml), endorsed by the State chapter of the American Academy of Pediatrics (NJ-AAP) and the New Jersey Breastfeeding

Task Force. The goal of the report is to present breastfeeding initiation as a quality of care issue, and to promote the included self-assessment tools and model hospital policy recommendations as tools for hospitals to improve their breastfeeding policies and practices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Professional outreach and education through MCH Consortia.				X
2. Surveillance from the Electronic Birth Certificate (EBC) and applied research projects.			X	X
3. Supporting the development of breastfeeding friendly policies in child care settings.				X
4. Surveillance of breastfeeding through the NJ PRAMS survey.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Many hospitals employed International Board Certified Lactation Consultants who identify early signs of breastfeeding difficulties and suggest appropriate options to the patients and medical staff. WIC Services funds breastfeeding promotion and support services for WIC participants through grants to five local WIC agencies and four MCH Consortia. WIC lactation consultants and breastfeeding peer counselors provide direct education and support services, literature, and breastfeeding aids, which include breast pumps, breast shells and other breastfeeding aids. WIC breastfeeding staff conducts professional outreach and education to healthcare providers who serve WIC participants.

c. Plan for the Coming Year

Hospitals should have received results of the CDC's mPINC Survey in November 2008. The national mPINC survey of maternity care feeding practices and policies is intended to help identify maternity care practices that hospitals can change to better support breastfeeding. Hospital-specific mPINC reports and the Breastfeeding and New Jersey Maternity Hospitals Report are new tools to be used to increase breastfeeding rates.

MCCH and WIC plan to partner with the MCH Consortia to hold a conference for maternity care providers in two locations. New Jersey hospital policy makers will be encouraged to use the CDC Guide to Breastfeeding Interventions to select evidence-based interventions and implement changes that are consistent with the "Ten steps to successful breastfeeding."

Dissemination of surveillance information on breastfeeding will be further expanded using birth certificate and PRAMS survey data. Efforts will also be made to improve the accuracy and collection of this data.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	99	99	99	99	99.2
Annual Indicator	98.8	98.8	99.2	99.2	99.6
Numerator	109060	108561	109181	111027	107740
Denominator	110401	109902	110054	111876	108168
Data Source					Newborn Hearing Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99.6	99.6	99.6	99.6	99.6

Notes - 2008
Provisional 2008 data from the Newborn Hearing Screening Program based on the EBC (as of 4/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Final 2008 data will be available in 2010.

Notes - 2007
2007 data from the Newborn Hearing Screening Program based on the EBC which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Notes - 2006
Final 2006 data from the Newborn Hearing Screening Program based on the EBC (as of 6/2008) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

a. Last Year's Accomplishments
Current data indicates that for 2008, 99.6% of infants were screened prior to discharge, a continued upward trend. Rates for children receiving follow-up after referring on inpatient screening continue to rise, but remain an area of focus.

In July 2008, changes were made to the EHDI module that is in the New Jersey Immunization Information System (NJIIS), the state's immunization registry. Updates incorporated changes to recommendations for follow-up that were included in the 2007 Joint Committee on Infant Hearing Position Statement. The NJIIS is utilized by audiologists and other around the state that are conducing follow-up to report outpatient exams with over 80% of reports coming in via this Web-based application instead of on the traditional paper form. Twenty-five new users were trained on the system during 2008.

The program attended Pediatric Department business meetings at 4 hospitals, educating over 200 physicians. The audiologist visited 12 facilities and discussed the EHDI process with over 38 individuals at these facilities. Additionally, the EHDI Audiologist gave 10 presentations to case

managers, services coordinators and public health nurses, educating over 225 health care professionals on the hearing loss in young children.

Site visits or conference calls to all 53 active birthing facilities in the State were made during 2008 by the EHDI staff, focusing this year on implementation of the 2007 JCIH Position Statement recommendations and including a case review for children who were not screened prior to discharge or who referred inpatient screening with no subsequent documentation. Quarterly reports were distributed to all hospitals comparing hospital performance to statewide averages and detailing children still needing follow-up.

The programs brochures "Can Your Baby Hear" and "Your Baby Needs Another Test" which were previously available in English and Spanish, were translated into 4 additional languages (Arabic, Korean, Polish, and Portuguese). The New Jersey Pediatric Hearing Health Care Directory was updated in May 2008 and posted on the EHDI web site.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Outreach to private practitioners.				X
2. Amended regulation for universal screening.				X
3. Hospital level surveillance reports.			X	
4. Increase in follow up and diagnostic reporting for those who fail screening.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

EHDI staff are scheduling educational presentations to pediatricians, audiologists, otolaryngologists and other health care professionals, focusing on the need to decrease rates of children lost to follow-up. A quality assurance initiative focusing on children insured under Medicaid managed care is currently underway in collaboration with staff from the Medicaid Office of Quality Assurance.

The New Jersey Pediatric Hearing Health Care Directory will be updated in late spring 2009. A parent brochure explaining choices in communication options is being developed.

c. Plan for the Coming Year

Ongoing activities to be continued for the coming year include hospital and audiology site visits. Quarterly reports continue to be sent to all hospitals to track success and progress. The EHDI program will continue to focus on improving rates of outpatient follow-up for children who do not pass their initial screening. The program will also focus on continued education of physicians, audiologists and hospital personnel involved in identification of hearing loss in newborns.

Educational visits to pediatrician offices will continue to be conducted, as will visits to private audiology offices. The AAP Chapter Champion for hearing screening plans to present several grand rounds on newborn hearing screening this year.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	10	9.5	9	10	12
Annual Indicator	11.7	11.3	13.6	13	13
Numerator	269256	258536			
Denominator	2299330	2292031			
Data Source					CPS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	11	10	9	9	8

Notes - 2008
Data for 2007 is entered as an estimate for 2008.

Final 2008 data will be available in Spring 2010.

Notes - 2007
Source: the Annual Social and Economic Supplement (ASEC) of the Current population Survey (CPS), which is conducted by the Bureau of the Census for the Bureau of Labor Statistics. The age group is children 0-18 years old.
http://www.state.nj.us/health/chs/documents/hic00_07.pdf
% uninsured is 13.0 with a numerator of 288,300

Notes - 2006
Source: the Annual Social and Economic Supplement (ASEC) of the Current population Survey (CPS), which is conducted by the Bureau of the Census for the Bureau of Labor Statistics. The age group is children 0-18 years old.
http://www.state.nj.us/health/chs/documents/hic00_07.pdf
% uninsured is 13.6 with a numerator of 299,274

a. Last Year's Accomplishments
Improving access to preventive and primary care health services for children is a departmental and divisional priority. To provide comprehensive and affordable health insurance to eligible uninsured children, New Jersey and the Federal government have joined as partners in NJ FamilyCare (formerly New Jersey KidCare). NJ FamilyCare, administered by the New Jersey Department of Human Services, started in 1998.

In July 2008 a health care reform bill was signed into law expanding the NJ FamilyCare Program and allowing NJ to reinstitute enrolling parents up to 200% of poverty. The bill also contains a KidsFirst mandate requiring that all children (18-years and younger) have health insurance as of July 2009. Beginning in the 2008 tax year, individuals who file a NJ income tax return must indicate whether their dependents have health insurance and if they do not they will be mailed

letters regarding health insurance options. Additionally, there are a number of market reforms in the bill including the introduction of age as a rating factor in NJ's individual insurance market. As of February 2009 there were 556,000 children enrolled in the expanded NJ FamilyCare initiative and 212,000 parents enrolled in the NJ FamilyCare program. In the course of developing NJ FamilyCare, the State learned that many poor children who are eligible for free health insurance under the State's Medicaid program are not enrolled. The aggressive marketing and outreach programs designed to enroll children in NJ FamilyCare are also being used to increase the number of children enrolled in Medicaid. If all children who are eligible for NJ FamilyCare or Medicaid enroll in these programs, then the percentage of children who are uninsured should drop to four percent. Of the approximately four percent of uninsured children who do not qualify for NJ FamilyCare or Medicaid, many experience temporary gaps in insurance coverage, usually as a result of changes in parental employment. If employer-sponsored health insurance continues to decline, NJ FamilyCare will not be able to reduce the overall number of uninsured children in the State. Unfortunately, the percentage of uninsured children in New Jersey has increased from 8.2% in 1999 to 13.0% in 2007.

The NJ Health Care Reform Act of 2008 directed the Commissioner of the Department of Human Services (DHS) to establish the Outreach, Enrollment, and Retention Work Group (Work Group) to develop a plan to carry out ongoing and sustainable measures to strengthen outreach to low and moderate income families who may be eligible for Medicaid, NJ FamilyCare or NJ FamilyCare ADVANTAGE, to maximize enrollment in these programs, and to ensure retention of enrollees in these programs.

The Work Group's membership includes representatives from the New Jersey Association of Health Plans, Affiliated Computer Services (ACS) Inc., NJ Policy Perspective, Association for Children of NJ (ACNJ), Legal Services of NJ, the NJDHSS, NJDHS, Banking and Insurance, Labor and Workforce Development, Education, Community Affairs, Agriculture, the Office of the Child Advocate and a public member to represent minorities. The Director of Rutgers Center for State Health Policy and representatives from the Department of Children and Families also participated in Work Group meetings.

Data from Rutgers Center for State Health Policy indicate that 293,790 NJ children (13.3 percent) under age 19 lacked health insurance coverage in 2006-07. Approximately 56,070 or 19 percent of these children live in families with incomes over 350 percent of the Federal Poverty Level (FPL) and are eligible for ADVANTAGE. Most of the remaining uninsured children, about 223,720 or 76 percent, are income eligible for free or subsidized coverage through NJ FamilyCare or Medicaid. According to information from DHS, Division of Family Development (DFD), the recession has caused a 50 percent increase in the number of individuals requesting assistance directly from the County Welfare Agencies from December 2007 to December 2008. Given the current economy and increases in the number of unemployed residents, it is likely that the number of uninsured children in NJ will continue to grow.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Outreach and Enrollment Plan				X
2. MOU with NJ FamilyCare				X
3.				
4.				
5.				
6.				
7.				
8.				

9.				
10.				

b. Current Activities
Recent changes in federal law give states new opportunities to streamline procedures for enrolling children in health insurance programs and improving the efficiency and effectiveness of enrollment and retention practices. NJ is the first state to take advantage of these new opportunities and is in the midst of executing an unprecedented direct outreach campaign. NJ developed an Express application for enrolling children in NJ FamilyCare and Medicaid and is mailing it to the households of the nearly 360,000 children who were identified as uninsured on state tax returns.

Based on the Work Group's research and discussion, barriers and recommendations were identified. A report, NJ FamilyCare Outreach, Enrollment and Retention Report May 2009, was produced which identifies findings and recommendations to help meet goals of the Reform Act.

To reduce the number of uninsured children in NJ (NPM #13), Reproductive and Perinatal Health Services continues to work with the Healthy Mothers, Healthy Babies (HMHB) Coalitions, Healthy Start Projects and Black Infant Mortality Reduction projects to facilitate enrollment of children whose mothers are served by the projects.

Atlantic City, Paterson, and Essex County HMHB coalitions have made FamilyCare enrollment one of their priority areas as an access to care issue. Outreach staff assists clients with accessing the system and completing the enrollment process.

c. Plan for the Coming Year
Recommendations to reduce barriers to health insurance enrollment for children and reduce the number of uninsured children are included in the Work Groups report - NJ FamilyCare Outreach, Enrollment and Retention Report May 2009 (http://www.acnj.org/admin.asp?uri=2081&action=15&di=1442&ext=pdf&view=yes).

Despite the fact that all relevant departments are willing to work cooperatively to achieve the goal, additional work is needed to coordinate and implement various activities. A thoughtful planning process among all government entities serving children and families is needed, in concert with technological improvements that will create a streamlined and coordinated assistance program infrastructure. An inclusive planning process to determine which technological improvements are necessary across departmental data systems is in place and moving forward.

Health Service grants funded by Reproductive and Perinatal Health services will continue to require agencies to outreach and facilitate enrollment of potentially eligible children. Outreach to pregnant women will include facilitating access to FamilyCare enrollment to ensure a smooth transition to a pediatric medical home for infants served by the infant mortality reduction projects.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			39	40	39
Annual Indicator		39.8	39.1	35.6	35.4
Numerator		60981	61327		

Denominator		153155	157001		
Data Source					WIC PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	34	34	34	34

Notes - 2008
Source: 2007 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see http://www.cdc.gov/pednss/what_is/pednss/index.htm)

Notes - 2007
Source: 2007 Pediatric Nutrition Surveillance report for New Jersey, Table 12C. Provided by the NJ WIC Program as compiled by the CDC (see http://www.cdc.gov/pednss/what_is/pednss/index.htm)

Historical data that could not be edited.

	% WIC Children 2-5 with BMI >=85%
2006	35.6
2005	35.4
2004	34.5
2003	34.9
2002	33.9
2001	33.0

Notes - 2006
Data from the 2006 WIC Pediatric Nutrition Surveillance System
Table 12C

2002 - 33.9%
2003 - 34.9%
2004 - 34.5%
2005 - 35.4%
2006 - 35.6%

a. Last Year's Accomplishments
The New Jersey Obesity Prevention Task Force was reconvened in fall 2007 and discussion about pending recommendations for next steps took place. OPTF is creating a volunteer speaker's bureau and developing a marketing plan to maintain the impetus of the obesity awareness campaign.

Two Child Health Regional Network meetings on "Nutrition and Physical Activity Strategies for the Early Childhood Population" utilizing the program: I am Moving, I am Learning (IMIL); Color Me Healthy (CMH); and PLAY Plus were held with public health nurses, Head Start, child care and LHD staff, and county Child Care Health Consultant Coordinators.

An application for CDC's 5 year competitive cooperative agreement for Nutrition, Physical Activity and Obesity Program was approved for funding March 17, 2008 and began July 1, 2008 and will

continue thru June 30, 2013.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing collection and reporting of weight and height in the NJ Child Weight Status Report.				X
2. Development of recommendations by the New Jersey Obesity Prevention Task Force.				X
3. Three Community Partnership for Healthy Adolescents grantees are exploring the feasibility of collecting and analyzing height and weight data from their respective school systems.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collection and evaluation NAPSACC data submitted by preschools implementing PLAY Plus is on-going.

The continuation application was prepared and submitted on April 6, 2009 to the CDC for year 2 of the NPAO cooperative agreement.

As part of the NPAO funding, a statewide strategic partnership meeting was convened on April 2, 2009 at the Robert Wood Johnson Foundation in Princeton. Approximately 100 partners attended and will be working to develop a revised state plan to address obesity. The event titled, A NEW Jersey….Shaping the Way We Live, aims at coordinating all efforts across the state to alleviate duplication and focus on best available evidence for success. A focus on policy and environmental change will help to make the healthy choice the easy choice and in the short term stabilize obesity rates and accompanying burden.

CDC's State Plan Index (SPI) was utilized to evaluate the OPAP created in 2006.

c. Plan for the Coming Year

The New Jersey Obesity Prevention Action Plan (OPAP) will be reviewed and revised to meet CDC milestones. The first milestone is that the current plan be revised by partners who are engaged to contribute or leverage their resources toward the development and implementation of the plan rather than a legislated Task Force. Second a process for establishing priorities and responsible entities (agencies or organization) for implementation of activities and delineation of timelines needs to be completed. Third, measurable program objectives, indicators to measure progress available data sources and methods for determining success have to be determined. Fourth, the OPAP needs to target six areas; physical activity, fruit and vegetables consumption, sugar sweetened beverages, energy dense foods, television viewing and breastfeeding. CDC's State Plan Index (SPI) can be utilized to evaluate the planning process, stakeholder participation, goals and objectives and the methods to implement the strategies; and, ensure that the original

OPAP document is enhanced to be aligned with meeting CDC milestones for a NPAO state plan. The state plan will be evaluated at least annually, thereafter.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			8	8	7.8
Annual Indicator		8.1	8.1	6.2	6.2
Numerator					
Denominator					
Data Source					NJ PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	5.8	5.6	5.4	5.2

Notes - 2008
2007 NJ PRAMS data entered as provisional estimate for 2008. Final 2008 data will be available in 2010.

Notes - 2007
Source of data is the NJ PRAMS survey as queried on the CDC PRAMS Ponder system.
Indicator is reported as 6.2% (CI 5.3% - 7.2%).
See NJ PRAMS website (http://www.state.nj.us/health/fhs/professional/prams.shtml) for briefs on maternal smoking.

Historical data for PM #15
2006 5.7%
2005 6.7%
2004 7.9%
2003 7.9%
2002 9.0%

Notes - 2006
2006 data is estimated from the NJ PRAMS 2002-2004 sample.

a. Last Year's Accomplishments
An MCCH staff member is a participant in the National Partnership to Help Pregnant Smokers Quit. AMCHP holds quarterly Technical Assistance Conference calls for this group.

New Jersey has formed a partnership with ACOG and continues to participate as needed. This is a statewide, interdisciplinary committee.

Mom's Quit Connection (MQC), a grant funded project that offers phone counseling to pregnant

women, MQC teaches the 5 A's approach to quit smoking to professionals to use with their clients.

Staff from the MCH Epidemiology Program collaborated with the CDC's Division of Reproductive Health on a paper titled, Smoking Patterns and Use of Cessation Interventions During Pregnancy which was published in the October issue of the American Journal of Preventive Medicine. Data used in the paper was from the NJ PRAMS (Pregnancy Risk Assessment Monitoring System) survey.

Statewide there have been many notable accomplishments to reduce smoking. From 2000 to 2007, cigarette taxes were increased from 80 cents per pack to $2.575 per pack (among the highest in the country). Legislation to ban smoking in all workplaces and indoor public places was passed in 2006. Adult cigarette smoking fell from 21% during the mid 1990s to 17.1% in 2007. NJ's telephone Quitline and internet-based Quitnet have together had over 88,000 users up to the end of 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Mom's Quit Connection offers 5 A's training throughout the state.		X		X
2. The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke.				X
3. 'A Healthy You = A Healthy Baby' educational campaign			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Mom's Quit Connection offers 5 A's training throughout the state. These classes are presented to private practitioners as well as large OB/GYN departments.

The Perinatal Addiction Prevention Project (PAPP) promotes a screening tool that identifies pregnant women who smoke. These women are then given referral information for available resources to help them quit.

The Maternal, Child and Community Health staff continues to participate in both the state and national partnerships.

In October 2008 Commissioner Heather Howard launched a campaign to raise awareness about the importance of early prenatal care and preconception health in healthy birth outcomes, including smoking cessation. The educational campaign, A Healthy You = A Healthy Baby, followed the September 2008 release of the Prenatal Care Task Force report, which recommended raising awareness of preconception care and family planning services among women before they get pregnant, to ensure a healthy pregnancy and a healthy baby.

c. Plan for the Coming Year
The PAPP coordinators will continue to strengthen the referral process once a woman is identified at risk for substance use/abuse.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	3.5	3	2.9	2.8	4.2
Annual Indicator	5.6	4.4	4.4	3.7	3.7
Numerator	33	26	26	22	22
Denominator	587620	585572	588624	588624	588624
Data Source					WISQARS, CDC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.7	3.6	3.3	3	3

Notes - 2008
2007 data entered as provisional estimate for 2008 data. Final 2008 data will be available from the CDC in 2010.

Notes - 2007
Source: WISQARS Injury Mortality Reports online at http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

Notes - 2006
Provisional 2006 data estimated from final 2005 data. Final 2006 data may be available from NCHS in Spring 2009.

a. Last Year's Accomplishments
DHSS supports the Mercer County Traumatic Loss Coalition, which brings together a wide variety of community partners (including schools, local government, police, fire and EMS, and health care providers) to develop plans to prevent and address suicide and other sudden traumatic death among children and adolescents.

A clergy conference, "Suicide: A Compassionate Approach to Intervention and Healing" this time for the Jewish clergy on October 29, 2008. Rabbis, Cantors, religious educations, youth leaders and bereavement group facilitators participated in this event held in West Orange, New Jersey.

Through collaboration with the Department of Human Services and the University of Medicine and Dentistry of New Jersey, the following trainings were provided: There were 341 attendees at the 6th Annual Suicide Prevention Conference "We Have Many Children but None to Spare" held on November 18, 2008 in East Hanover, New Jersey and on November 19, 2008 in

Somerset, New Jersey.

A free Trauma and Grief in Youth Workshop was held in three locations: January 5, 2009 at University Behavioral Health Care in Piscataway, New Jersey and on January 6, 2009 in Wayne, New Jersey and on January 8, 2009 in Pomona, New Jersey. Over 380 participants were registered.

The Traumatic Loss Coalitions for Youth publishes a newsletter. Over 3,000 individuals are in receipt of this newsletter.

For New Jersey residents aged 15-19 years, the provisional suicide rate per 100,000 is 3.9 for 2007 based on 23 deaths.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. NJ Suicide Planning Team				X
2. Traumatic Loss Coalitions in 21 counties		X		X
3. "Managing Sudden Traumatic Loss in the Schools" - Manual				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
"Managing Sudden Traumatic Loss in the Schools" (revised edition) is made available to schools and other youth serving organizations upon request. The document outlines a model for responding to the needs of the general school population after a suicide, homicide or sudden accidental death.

The Office of Injury Surveillance and Prevention (OISP) in the Center for Health Statistics is a central source for injury and suicide statistics as well as home to several special injury projects. OISP is working to integrate surveillance data with injury prevention and control efforts. OISP release a report in October 2008 titled Suicide and Firearm Ownership, New Jersey, 2004-2006.

c. Plan for the Coming Year
DHSS continues to work with a wide variety of community partners, such as the Mercer County Traumatic Loss Coalition, to develop plans to prevent and address suicide and other sudden traumatic deaths and losses among children adolescents and families.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	88	85	85	80	80

Annual Indicator	83.9	80.5	77.6	76.7	82.6
Numerator	1438	1398	1379	1315	1446
Denominator	1713	1737	1776	1714	1751
Data Source					EBC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	83	83	83	84	84

Notes - 2008
Provisional 2008 data from the Electronic Birth Certificate file as of 5/6/2009. Final 2008 data may be available in Spring 2011.

Notes - 2007
2007 data from the Electronic Birth Certificate file as of 5/6/2009.

Notes - 2006
Provisional 2006 data from the Electronic Birth Certificate file as of 6/15/2008. Final 2006 data may be available in Spring 2009.

a. Last Year's Accomplishments
The state has made consistent progress on NPM #17. However, despite improvements in Neonatal Intensive Care Units (NICU) and community-base efforts that focus on early admissions to prenatal care and comprehensive services, we have not observed improvements in the rate of infants born at low birth weights. Overall trends in both low and very low birth weights indicate a small but steady increase in the number of infants born at these weights. A significant refinement in the reporting of LBW rates is the reporting of singleton LBW and singleton VLBW rates as Health Status Indicators. The rapid increase in multiple births due to assisted reproductive technology has influenced overall LBW and VLBW rates. Singleton LBW and singleton VLBW rates are stable or slightly decreasing.

The percent of VLBW infants delivered at facilities for high-risk deliveries and neonates has increased through continuous quality improvement activities, which are coordinated on the regional level by the Maternal and Child Health Consortia (MCHC). The FHS/Perinatal Services coordinates regional continuous quality improvement activities within each of the 6 regional MCHCs. Regional quality improvement activities include regular monitoring of indicators of perinatal and pediatric statistics and pathology, including 1) transports with death; 2) non-compliance with rules regarding birth weight and gestational age; 3) cases in which no prenatal care was received; 4) all maternal deaths; 5) all fetal deaths over 2,500 grams not diagnosed as having known lethal anomalies; 6) selected pediatric deaths and/or adverse outcomes; 7) immunizations of children 2 years of age; and 8) admissions for ambulatory care sensitive diagnoses in children.

Quality improvement is accomplished through fetal-infant mortality review and maternal mortality review systems, as well as analyzing data collected through the electronic birth certificate (EBC). Currently, all hospitals providing maternity services report births through the EBC. The Consortia monitor the accuracy of data entered into the EBC and provide training and technical assistance as needed. Data collected by each Consortium through the EBC reflects births that occur in each Consortium's member hospitals only. The MCH Consortia recommend, implement, and monitor

corrective action, based upon the data collected. A multidisciplinary committee that includes representation from member hospitals and the community oversees the total quality improvement process within the Consortium. Data collected through the EBC and the NJ Maternal Mortality Review and NJ Fetal-Infant Mortality Review are presented to the Consortium TQI Committee. The TQI Committee reviews the data and makes recommendations to address either provider specific issues or broad system issues that address multiple providers or consumer groups within each Consortium region. Data and information gleaned from regional TQI activities is forwarded to the FHS/Perinatal Services, which will be included in a combined database used for planning on a statewide level.

As a follow-up to the Perinatal and Pediatric Bed Need Task Force, a statewide collaborative partnership to gather and analyze data related to quality of care for newborn infants and their families was convened. Most of the Regional Perinatal Centers (RPCs) are members of the Vermont Oxford Network (VON) and believe that the prenatal and postnatal data available through this network could improve the system of total quality improvement on a regional and statewide level. The Chief of Neonatal Medicine from the Regional Perinatal Centers and the Executive Director of each of the regional MCH Consortia attended a series of meetings in 2007 to develop this total quality improvement project.

The Directors of Neonatalogy of the Regional Perinatal Centers have been meeting to develop the New Jersey NICU Collaborative. All 15 Regional Perinatal Centers have submitted the documents necessary to participate in the New Jersey Neonatal Collaborative to establish a statewide reporting program based on the hospital-level NICU performance data submitted to the Vermont Oxford Network, Inc. Each participant agreed to the principles outlined below for the development and implementation of performance improvement strategies in Neonatal Intensive Care Units ("NICUs") in New Jersey. The 15 centers received the comparative data from VON for the years 2006 and 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. MCH Consortia TQI Activities				X
2. Perinatal Designation Level regulations				X
3. Development of the New Jersey VON Collaborative				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The regional quality improvement activities within each of the 6 regional MCHCs coordinated by the FHS/Perinatal Services include the regular monitoring of indicators of perinatal and pediatric statistics and pathology listed above, fetal-infant mortality review, maternal mortality review, and maternity services reporting through the EBC.

The Directors of Neonatology of the RPCs have been meeting to develop the NJ VON Collaborative. The participants acknowledge that the goal of the Collaborative is to improve the quality and outcomes of perinatal health care in NJ through the adoption of VON's mission - to improve the quality and safety of medical care for newborns and their families through a

coordinated program of research, education and quality improvement project. The purpose of the Collaborative is to ensure: the development of a voluntary, collaborative network of neonatal providers, to support a system for bench marking and continuous quality improvement activities for perinatal care; the opportunity to develop a responsive, real time, risk-adjusted, statewide perinatal data system; and the ability to integrate existing state and front-end perinatal data systems.

The New Jersey NICU Collaborative reached consensus to proceed with the first quality improvement project addressing the issue of infection. Three groups have been formed based on geography, north, central and south.

c. Plan for the Coming Year
The NJ NICU Collaborative plans to perform site visits among the centers. The Collaborative is considering a professional conference or other forum to share information with the NICU's, the Department and the Maternal and Child Health Consortia.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	79	79	79	79.2	79.2
Annual Indicator	78.6	77.9	77.1	76.6	78.4
Numerator	88136	86278	86158	86363	85891
Denominator	112117	110697	111727	112715	109539
Data Source					EBC
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	79.4	79.6	79.8	80	80.2

Notes - 2008
Source: 2008 provisional data from the Electronic Birth Certificate file as of 5/6/2009. Final data will be available in 2011.

Notes - 2007
Source: 2007 provisional data from the Electronic Birth Certificate file as of 5/6/2009. Final data will be available in 2010.

Notes - 2006
Source: 2006 provisional data from the Electronic Birth Certificate file as of 5/17/2008. Final data will be available in 2009.

a. Last Year's Accomplishments
Through the Healthy Mothers Healthy Babies (HM/HB) Coalition program, the enabling services of outreach, supportive services, and education are provided to improve maternal and infant care (National Performance Measures #18, #5, #17, and Health Status Indicators #2, #3, #4, #5). The percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester and the percentage of infants born to pregnant women receiving adequate prenatal care (Kotelchuck Index) have slowly increased over the last decade.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Mothers Healthy Babies coalition activities				X
2. MCH Consortia outreach and education activities				X
3. HealthyStart				X
4. The Commissioner's Prenatal Care Task Force				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
To improve early prenatal care in New Jersey, Health Commissioner Heather Howard convened The Commissioner's Prenatal Care Task Force in February 2008. The Task Force was comprised of physicians, nurses, administrators and others with expertise in maternal and child health. The Task Force presented a report and recommendations to Commissioner Howard in July 2008.

Commissioner Howard launched a public awareness campaign statewide using a variety of venues including Healthy Mothers, Healthy Babies, MCH Consortia, hospitals, federally qualified health centers, colleges and others. Previously funded initiatives will begin to be phased out effective April 2009. A request for applications is under development to implement recommendations contained in the Commissioner's Prenatal Care Task Force Report. This competitive request for applications seeks to improve and provide quality access to prenatal care, preconception and interconception care as a means to decrease infant mortality rates. It is anticipated that projects seeking funding should be able to produce measurable positive outcomes in increasing the number of women accessing prenatal care in the first trimester and or increasing access for reproductive age women and their partner for preconception and interconception care.

c. Plan for the Coming Year
Release the competitive request for applications with planned implementation of new projects by January 2010. Continue public awareness campaign with the MCH Consortia to distribute posters and other information.

The Atlantic City HM,HB Coalition will: conduct outreach to identify 50 women in need of prenatal or postpartum care; provide education and follow-up to ensure continued care; educate 500 women on the importance of preconception care; and sponsor a Mother Daughter Day of Health.

The Camden HM,HB Coalition will: provide case management for 75 high risk pregnant women;

reconnect 150 pregnant women "lost to care"; provide education and follow-up to ensure continued care; identify 75 pregnant women in their first trimester who are not receiving care, educate them and connect them to services; and sponsor a Fatherhood event.

The Essex HM,HB Coalition and 5 subgrantees will: sponsor a outreach workers conference; identify 40 pregnant women not receiving prenatal care; provide education, referrals and follow-up to ensure continued care; conduct outreach activities to educate 7,000 residents on perinatal health issues; reconnect 150 pregnant women "lost to care"; and provide education, follow-up to ensure continued care, and case management to 3,500 pregnant or post-partum women.

The Jersey City HM,HB Coalition will: identify 60 pregnant women not receiving prenatal care; provide them education, service referrals and follow-up to ensure continued care; sponsor a conference on infant mortality reduction for 50 professionals and 25 consumers; conduct workshops for 4,000 women on infant mortality reduction; and provide preconception information to 6,000 women.

The New Brunswick HM,HB Coalition will sponsor 2 outreach worker trainings and participate in 12 community events. The Coalition awarded a subgrant to provide parenting/baby care classes for 600 parents and identify women "lost to care," to educate them on the importance of care, to reconnect them to services, and to provide follow-up to ensure continued care.

The Paterson HM,HB Coalition will: identify 100 pregnant women "lost to care"; educate them on the importance of care; reconnect them to services and follow-up to ensure continued care; and educate 3,000 high school and 100 grammar school students on the risks associated with teenage pregnancy.

The Plainfield HM,HB Coalition will sponsor a "Game of Life" and participants in 12 community events. The Coalition awarded a subgrant to assure prenatal care for 25 women not receiving services and to assure continued services for 125 women or infants "lost to care."

The Trenton HM,HB Coalition will: provide case management for 125 high-risk mothers; and assure prenatal care for 25 pregnant women not receiving services. The Coalition awarded a subgrant to provide preconception, prenatal, and post-partum information in English and Spanish and prenatal classes and support groups for 40 Latina women.

D. State Performance Measures

State Performance Measure 1: *The percentage of Black non-Hispanic preterm infants in New Jersey*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	13.2	13.2	13.1	13	13
Annual Indicator	11.6	11.5	12.1	11.3	11.0
Numerator	1912	1866	2039	1945	1861
Denominator	16447	16221	16864	17256	16858
Data Source					EBC
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	12	12	11.5

Notes - 2008

Provisional 2008 data from the Electronic Birth Certificate file as of 5/6/2008. Final 2008 data will be available in 2011.

Notes - 2007
2007 data from the Electronic Birth Certificate file as of 5/6/2009.

Notes - 2006
2006 data from the Electronic Birth Certificate file as of 5/6/2009.

a. Last Year's Accomplishments
Maternal, Child and Community Health chose the percent of black preterm births in New Jersey as State Performance Measure #1. Previous sections concerning the Blue Ribbon Panel on Black Infant Mortality Reduction, the Black Infant Mortality Reduction Advisory Council, the BIBS campaign and MCH activities demonstrate the department's commitment to reduce black infant mortality. Infants who are born preterm are at the highest risk for infant mortality and morbidity. The percentage of black preterm births was selected to begin to address the underlying causes of black infant mortality and the racial disparity between preterm birth rates.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Healthy Mothers /Healthy Babies Coalitions			X	X
2. Healthy Start		X		X
3. Preconceptual health counseling/training				X
4. HealthStart				X
5. MCH Consortia outreach and education activities			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Reproductive and Perinatal Services has implemented program evaluation of all funded BIMR activities.

c. Plan for the Coming Year
Six health service grants were awarded to a variety of health service agencies to implement innovative approaches to reduce the high incidence of black infant mortality. These strategies include outreach and education, case management, prenatal and postnatal healthcare prevention and social service support, community awareness activities on the issue of black infant mortality and multifaceted communication programs via websites.

State Performance Measure 2: *The percentage of Regional MCH Consortia implementing community-based Fetal and Infant Mortality Review (FIMR)Teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100

Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	6	6	6	6	6
Denominator	6	6	6	6	6
Data Source					Maternal Child & Community Health Service Unit
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Source: Maternal Child & Community Health Service Unit

Notes - 2007
Source: Maternal Child & Community Health Service Unit

Notes - 2006
Source: Maternal Child & Community Health Service Unit

a. Last Year's Accomplishments
State Performance Measure #2 was selected to monitor progress toward the implementation of community-based Fetal and Infant Mortality Review Teams (FIMR). This infrastructure building service will impact on National Performance Measures #15, #17, #18 and all of the perinatal outcome measures. Increasing the understanding of the circumstances and factors associated with fetal and infant deaths will advance the State's ability to assess needs, improve the social and health care delivery system, and target resources and policies toward specific locations.

On a local level, the MCH Consortia have used FIMR as a component of their quality improvement program both for need assessment and program development. Findings are shared with member hospitals for use in quality assurance activities. Policy has been implemented, such as the promulgation of fetal autopsy guidelines and consumer and professional education initiatives have addressed findings such as inadequate knowledge of fetal kick count and premature labor, and bereavement support issues.

Until the implementation of the NJ FIMR, there has not been a statewide approach to FIMR. Therefore, FIMR findings have not played a major role in need assessment and quality improvement at the state level. NJDHSS and the MCH Consortia are now working collaboratively to use the information obtained from NJ FIMR for policy development and continuous quality improvement activities on the state and local level. In addition to issuing a Statewide Annual NJ FIMR report, common areas of concern identified from the local reviews will be addressed as a collaborative effort by all local projects through statewide initiatives.

Related to FIMR is New Jersey's system of Maternal Mortality Review (MMR), which was established, in the late 1970s and revised in 1999. The revised New Jersey Maternal Mortality Review is based on the National Fetal-Infant review process, using a multidisciplinary model, data abstraction, de-identified case summary, and Community Action Teams to implement programs to effect change. The FHS/Reproductive Health and Perinatal Services coordinates the New Jersey MMR process.

All pregnancy-associated deaths occurring in 1999 through 2005 have been reviewed. The Case Review Team, which also serves as the Community Action Team, has reviewed the findings and made recommendations. A report of the findings and recommendations for the year 2 years 1999-2005 is expected in the summer, 2009..

A birth certificate, death certificate and hospital discharge data matching strategy is used to

improve identification of maternal deaths using the CDC expanded definition of pregnancy-associated death. Once cases are identified, Reproductive and Perinatal Health Services verifies the cases by reviewing the death certificate, autopsy report, Report of the Investigation of the Medical Examiner, law enforcement records, or by contacting the hospital or health care provider directly. Cases deemed pregnancy-associated deaths are entered into a log. A copy of the log and death certificates is forwarded to the Central New Jersey Maternal and Child Health Consortium for data abstraction. The CNJMCHC coordinates data abstraction through a grant from DHSS. Data abstractors are nurses with extensive maternal and child health backgrounds, trained in medical data abstraction, and case summary development.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementing NFIMR in six MCHC Regions.				X
2. Implementation of FIMR process uniformly across all projects.				X
3. Reporting of data and local findings to NJDHSS for inclusion in statewide database.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The number of FIMR projects statewide continues to be 9, of which 7 are funded with MCH Block Grant monies through the 6 regional MCH Consortia. In order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective, the process is implemented uniformly across all projects. All local projects of NJ FIMR follow the National FIMR guidelines for community FIMR with modifications as needed for NJ. The data collection process includes both chart abstraction and a maternal interview. A multidisciplinary case review team reviews the information and based on findings, makes recommendations to a Community Action Team. Data and findings from FIMR projects are submitted to the NJDHSS for inclusion in a statewide database.

Obtaining the maternal interview continues to be an impediment to the process. The success in obtaining maternal interviews has improved through the use of nurses through contracting with a local health department or VNA. However, obtaining a maternal interview continues to be a challenge.

c. Plan for the Coming Year

All local projects of NJ FIMR will follow the National FIMR guidelines for community FIMR in order to assure a process that will allow for coordination of NJ FIMR findings from a statewide perspective. Data and findings from local FIMR projects will continue to be submitted to the NJDHSS for inclusion in the statewide database. The Reproductive and Perinatal Health Services will continue to coordinate the NJ Maternal Mortality Review process modeled after the National FIMR process.

State Performance Measure 3: *The percentage of children with elevated blood lead levels (>=20 ug/dL).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	0.4	0.3	0.3	0.2	0.2
Annual Indicator	0.3	0.4	0.3	0.2	0.2
Numerator	543	628	450	350	273
Denominator	167018	173141	179158	161776	174647
Data Source					Childhood Lead Prevention Program Database
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	0.2	0.1	0.1	0.1	0.1

Notes - 2008
Source: Childhood Lead Prevention Program Database, MCCH, FHS.
for Federal Fiscal Year 2008. Final 2008 data will be available in Spring 2010.

Notes - 2007
Source: Childhood Lead Prevention Program Database, MCCH, FHS.
for Federal Fiscal Year 2007.

Notes - 2006
Source: Childhood Lead Prevention Program Database, MCCH, FHS.
for calender year.

a. Last Year's Accomplishments
The percent of children with elevated blood lead levels (State Performance Measure # 3) was chosen because children in New Jersey have a higher than average exposure to lead in their environment and a higher percentage of elevated blood lead than the national average. In State FY 2007, 1.8% of children tested for lead poisoning in New Jersey had elevated (> 10 ug/dL) blood lead levels. Children with elevated blood lead levels are at increased risk for behavioral problems, developmental delays, and learning disorders. Increased childhood morbidity will result from undetected and untreated lead poisoning.

Significant progress was made toward SPM # 3 regarding childhood lead poisoning prevention. During calendar year 2008, more than 222,000 blood lead tests were reported on 208,860 children. Of the children tested during calendar year 2008, 83.8% were under the age of 6 years. Among these children, 0.9% had results > 10 ug/dl and 0.2% had results > 20 ug/dl. Of all the children tested, 100,264 were between six months and 29 months of age, the ages at which state rules require all children to be screened for lead poisoning. This is 44.9% of all children in that age group. Looking at all blood lead tests reported since 1999, it is estimated that 75% of children have had at least one blood lead test by the age of two years, and 54% of children have had at least one blood lead test by the age of 1 year

A new web-based data and surveillance system (LeadTrax) containing medical and environmental case management modules was customized and implemented as of July 1, 2006. This surveillance system is accessible to local health departments 24 hours a day, 7 days a week, by means of the Internet. LeadTrax is able to track non-paint sources of lead, share data and populate other data systems (such as New Jersey Immunization Information System), and

enhance communication between DHSS staff and local health departments. LeadTrax has tools for improved de-duplication of records and cleaning of data, electronically exporting quarterly surveillance extracts to the CDC, and generating summary reports. In addition, LeadTrax is CDC compliant. The LeadTrax user base has been in an incremental expansion mode, at the rate of about four local health departments each month, by means of hands-on training and access for the users in those local health departments

During calendar year 2008, because of ongoing efforts, the percentage of electronic reporting increased to 97% from the calendar year 2007 rate of 96%. This surpasses the rate that was originally anticipated by the end of State Fiscal Year 2008 (95%). DHSS is in the process of assisting remaining laboratories to make the transition from hard copy to electronic reporting. with LeadTrax, more laboratories will be able to report electronically because of the system's capability to accept HL7 and Microsoft Excel reporting templates, which were developed exclusively for screening sites that use LeadCare analyzers.

The project to create Geographical Information System (GIS) maps using childhood lead poisoning data and housing data, exhibiting lead poisoning and screening distribution, along with the distribution of pre-1950 houses in the State, was completed in 2008. This project was through a partnership with DHSS' Center for Cancer Initiatives of New Jersey and the Department of Community Affairs (DCA). The maps were shared with the grantee agencies to help them design their targeted screening and education plans.

Collaborative efforts with Medicaid and its contracted managed care providers continue in order to monitor and increase the number of Medicaid-enrolled children screened for lead poisoning.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Surveillance system enhancements and universal electronic reporting.			X	X
2. Newark Partnership for Lead Safe Children.			X	X
3. Medicaid collaboration on pilot screening projects.				X
4. Regional Childhood Lead Poisoning Prevention Coalitions.			X	X
5. Plan for Elimination of Childhood Lead Poisoning in New Jersey.				X
6. Nurse case management and environmental investigation protocol enhancements for highest risk jurisdictions (>=15 ug/dl).			X	X
7. Targeted screening enhancements (children exposed to parental occupational exposure, refugee children to age 16 years).			X	X
8.				
9.				
10.				

b. Current Activities

The expansion of the LeadTrax users base from local health departments continues to be a priority with an expected completion date December 2009.

In 2008, the DHSS published the FY 2007 Annual Report on Childhood Lead Poisoning in New Jersey for dissemination of this data to local health departments and the public.

Focus is on the involvement of child care providers as access points for lead poisoning

prevention education, enhancement of community partnerships for resource and referral, and age-appropriate screening of children in collaboration with local health departments and other community-based health care providers.

c. Plan for the Coming Year

LeadTrax access will continue to be expanded to ultimately having all local health departments in the State access to it. LeadTrax will also be customized further as needed.

DHSS will continue to place a greater focus on implementing primary prevention initiatives and strengthening strategic partnerships at all levels. State partners include other Divisions and Programs within DHSS (e.g. Refugee Health, Occupational Health, Food and Drug Safety Program), Department of Community Affairs which is responsible for the development and enforcement of state housing codes and standards, Department of Human Services (Medicaid), Department of the Public Advocate, and Department of Children and Families. Efforts will focus on identifying and addressing lead hazards prior to young children moving into units or homes, as well as identifying lead-safe housing for families in need of emergency relocation due to a lead poisoned child. Monitoring of the Elimination Plan will be coordinated by DHSS to assure that the state is collectively making progress to eliminate childhood lead poisoning. A conference, scheduled for October 2009, is being planned by the Interagency Task Force on the Prevention of Lead Poisoning to highlight the State's accomplishments and new collaborations and initiatives that address lead poisoning prevention. The conference's three tracks will focus on health, housing, and the environment. DHSS will continue to provide technical assistance to the eight Lead Safe Model Cities in implementing their signed agreements with the Department of the Public Advocate.

In the highest risk city, Newark, the CLPP Program will continue to partner with the Newark Department of Child and Family Well-Being to sustain the Newark Partnership for Lead Safe Children. The Partnership was developed to empower the city and participating organizations to build local capacity to address the lead problem in Newark. In 2008, CDC issued a contract to the National Center for Healthy Housing to provide technical assistance for all areas of the city's CLPP Program, focusing on strategies that will assure progress toward the goal of eliminating childhood lead poisoning. Initiatives include the development and wide distribution of a resource directory of services needed by families affected or potentially affected by lead poisoning, enhanced collaborations with the city housing authority and other agencies providing housing-related services, and lastly, the development and enforcement of protective policies.

All children in target areas with elevated blood lead levels that require public health intervention are eligible for Childhood Lead Poisoning Prevention (CLPP) Project services as described earlier in this section. Children in other areas of the State with elevated blood lead levels are served by their local health department as required by the State Sanitary Code (Chapter XIII).

State Performance Measure 4: *The percentage of repeat pregnancies among adolescents 15 - 19 years of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6	5.8	5.7	5.6	5.5
Annual Indicator	5.8	5.9	6.3	5.7	6.1
Numerator	404	408	448	411	426
Denominator	6917	6865	7139	7258	6973
Data Source					EBC

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	5.5	5.4	5.4	5.3	5.3

Notes - 2008
Provisional 2008 data from the Electronic Birth Certificate file as of 5/6/2009. Final 2008 data will be available in Spring 2010.

Notes - 2007
Provisional 2007 data from the Electronic Birth Certificate file as of 5/6/2009.

Notes - 2006
2006 data from the Electronic Birth Certificate file as of 5/7/2008.

a. Last Year's Accomplishments
The Adolescent Pregnancy Program at FamCare was transitioned to the Parents as Teachers (PAT) model. FamCare is funded to implement this model by the Department of Children and Families.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Comprehensive services for teens through Family Planning sites.	X			X
2. Adolescent parenting project (AAP)		X		X
3. Advisory Council on Adolescent Pregnancy Prevention completion of a three-year strategic plan.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The APP at FamCare is in the process of transitioning their program form APP to the PAT model. This transition will be completed by June 30, 2008 at which time FamCare will be fully funded by the Department of Children and Families for implementation of this model.

c. Plan for the Coming Year
There will not be any funded initiatives in Adolescent Health addressing this measure since the APP at FamCare was the only grantee.

State Performance Measure 5: *The percentage of State supported initiatives implemented for improving the nutrition and physical activity of children and adolescents*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective			100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	7	12	12	12	12
Denominator	7	12	12	12	12
Data Source					Source: Child & Adolescent Health Programs
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
Source: Child & Adolescent Health Programs, FHS.

Notes - 2007
Source: Child & Adolescent Health Programs, FHS.

Notes - 2006
Source: Child & Adolescent Health Programs, FHS.

a. Last Year's Accomplishments
The NJCPFS funded 22 mini-grants from throughout NJ for promoting health and physical activity in their communities.

As part of the MOA with Rutgers Cooperative Extension the Get Moving, Get Healthy NJ! Website (www.getmovinggethealthynj.org) aimed at increasing youth and family access to nutrition was launched. In addition, the 9th Childhood Obesity Summit was held in Morris County on November 2nd and 180 stakeholders attended this event aimed at encouraging the community to participate in activities to assist youth and families. A second Child Health Summit is pending as are 8 Family Fun Night events.

Child and Adolescent Health staff and the Office of Local Health are exploring ideas of how MAPP teams and their CHIPs (most reflect obesity as a priority) might be used, as the umbrella for county coalitions (infrastructure), to address nutrition and physical activity, obesity and 5-A-Day initiatives. Training for the obesity sub-committee of MAPP team members is being proposed for the OPTF statewide conference.

The Osteoporosis Awareness and Education Act became law in 1997 but does not include a state appropriation. Osteoporosis activities are coordinated with the Division of Senior Affairs, in consultation with the Interagency Council on Osteoporosis (ICO). Currently, the KidStrong (Inside & Out) curriculum will be reviewed and revised by Rutgers Cooperative Extension and consideration will be given to its use as both an osteoporosis and obesity prevention strategy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Revision of the Obesity Prevention Action Plan to determine priorities.				X
2. Three Community Partnership for Healthy Adolescents grantees are continuing efforts to address nutrition and physical activity with 10-17 year old youth.				X
3. Collaboration with PLAY Task Force and the legislated Interagency Council on Osteoporosis (ICO) on a statewide pre-				X

school education initiative for providers, families and pre-school aged children.				
4. Healthy Community Development mini grants.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The New Jersey Obesity Prevention Action Plan (OPAP) will likely be reviewed to meet CDC milestones. The first milestone is that the current plan be revised by partners, rather than a legislated Task Force, who are engaged to contribute or leverage their resources toward the implementation of the plan. Second, a process for establishing priorities, responsibilities for implementation of activities and delineation of timeliness, needs to be completed. Third, measurable program objectives, indicators to measure progress available data sources and methods for determining success have to be determined. Fourth, the OPAP needs to focus on six areas: physical activity, fruit and vegetable consumption, sugar sweetened beverages, energy dense foods, television viewing and breastfeeding. CDC's State plan Index (SPI) is a tool that can be utilized to evaluate the planning process, stakeholder participation, goals and objectives and the methods to implement the strategies; and, ensure that the original OPAP document is enhanced to be aligned with meeting CDC milestones for a NPAO state plan. The state plan will be evaluated at least annually, thereafter.

c. Plan for the Coming Year

A NEW Jersey…Shaping the Way We Live! was launched to enlist the commitment of diverse partners from across the state that will address obesity. By the end of this year (July 2009 - June 2010) a new state partner plan will be completed, approved and submitted to the Centers for Disease Control and Prevention.

The success of this state partnership is founded on the state health department building an infrastructure to support its development. Partners will work within seven workgroups that they created to address obesity: increased physical activity; increased fruit and vegetable consumption; increased breastfeeding initiation, duration and exclusivity; decreased TV viewing; decreased energy dense foods and sugar sweetened beverages; partnership development and sustainability; and surveillance and evaluation. These groups will focus on policy and environmental change so that the healthy choice becomes the easy choice for New Jersey residents, use resources for those at greatest risk for obesity and other chronic diseases and utilize evidenced based strategies. Each workgroup will develop targeted priorities with data needs identified and measurable outcomes determined. Implementation of the strategies by partners will be undertaken once this year long phase is completed.

State Performance Measure 6: *The percentage of children with birth defects who are appropriately reported to the New Jersey Birth Defects Registry.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	87	87	88	88	89
Annual Indicator	86.6	88.8	88.8	89.9	89.9

Numerator	1289	1359	1359	1466	1466
Denominator	1488	1531	1531	1630	1630
Data Source					NJ Birth Defects Registry
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	91	92	92

Notes - 2008
Source: Provisional 2007 NJ Birth Defects Registry entered as an estimate for 2008 data. Final 2008 data will be available in 2010.

Notes - 2007
Source: Provisional NJ Birth Defects Registry. Final data is pending further hospital medical cahrt audits.

Notes - 2006
Source: NJ Birth Defects Registry.

a. Last Year's Accomplishments
SPM #6 was chosen to improve the quality of the Birth Defects Registry (BDR) which has been an invaluable tool for surveillance, needs assessment, service planning and research. NJ has the oldest requirement in the nation for the reporting of birth defects, starting in 1928. Since 1985, NJ has maintained a population-based BDR of children with all defects. Starting in 2003, the SCHS Registry received a CDC cooperative agreement for the implementation of a web-based data reporting and tracking system. In 2007, NJ legislation passed legislation mandating the reporting of Autism. As a result of this legislation, the BDR will add autism as a reportable diagnosis to the BDR. The proposed rules include expanding the mandatory reporting age to birth through age 5 and adds severe hyperbilirubinemia as a reportable condition.

Bloustein Center for Survey Research (BCSR) at Rutgers continued development of the new BDR System (BDRS). Due to the inclusion of Autism reporting within the BDR, discussions were held with EIS's staff to identify the information needed to include children diagnosed with autism into the BDR and to identify any modifications to existing procedures to meet the new legislation requirements. These discussions resulted in the development of a supplemental registration form, which will be included in an electronic format in the BDRS, for registering children with autism-related diagnoses.

BCSR continued to work with EIM Program staff and staff from the SCHS county-based Case Management Units to conceptualize the development of the case tracking and management component of the BDRS. As a result of these discussions, BDR staff developed electronic forms for routine case management activities, including the Individual Family Service Plan (IFSP), child-specific case manager activities, and State and federally required reports.

In anticipation of registrations for children with autism-related diagnoses, actions were taken to prepare for the enhanced surveillance activities related to these children. In cooperation with the Governor's Council on Medical Research and Treatment of Autism, in addition to the development of a supplemental form for registering children with an autism-related diagnosis, a standardized stand alone data system was developed for use by the 6 funded Autism Centers to collect basic demographic, medical and psychological evaluation, and treatment information. This information, with all proper controls, will be analyzed by EIM Program and Autism Centers staff to better understand the epidemiology and treatment of autism.

The web-based BDRS electronic registration component, which will begin implementation by July 2009, will facilitate improvements in reporting from hospitals and medical providers through a secure and HIPAA-compliant Virtual Private Network. The case management component will be

implemented about 12 months later.

In 2008, the SCHS Registry:
• Processed nearly 12,000 registrations,
• Identified over 8,300 new children with birth defects and other special health needs,
• Updated about 1,100 records of previously registered children,
• Referred over 8,100 families to the SCHS County-based Case Management Units, and
• Received over 250 autism-related registrations

In addition to identifying children through the formal registration process, the Program has continued its quality assurance measures to assure children are properly reported to the BDR. In this process, BDR staff identified non-reported children by cooperatively working with birthing hospitals, Early Hearing Detection and Intervention (EHDI) Program, and NJEIS. The Program conducted their annual audit at all birthing hospitals and one children's specialty hospital to identify children who were not registered. During the audits, education was provided on the use of the new registration forms, which included providing a detailed instruction manual, the progress on the electronic BDRS, and changes to the legislative rules detailing the reporting of birth defects, autism, and hyperbilirubinemia. A quarterly report, which lists all children registered by the hospital, was sent to each birthing hospital to ensure that all children with mandated birth defects are reported to the SCHS Registry. The Program also worked with the EHDI Program and NJEIS to register children having any level of hearing loss, who were known to these programs, but had not been registered with the SCHS Registry.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Annual Audits				X
2. Collaboration of 1 of 8 National Centers for Birth Defects Research and Prevention Quarterly reports to hospitals.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Annual audits performed by the SCHEIS staff are necessary to identify children with birth defects that would otherwise not be entered into the Registry. The audits, performed at every maternity hospital and facility with pediatric beds, provide an opportunity for Registry staff to present reporting performance back to each facility. This year, registry staff audited each of the 54 birthing facilities in NJ and each of the 21 County Case Management Units. While birth defects affect 3-5% of all newborns and are a leading cause of infant mortality, the cause of 67% of birth defects is unknown. Improving the infrastructure and quality of surveillance data is a prerequisite for developing better programs and advancing research toward prevention. Provisional data from the most recent audit shows that hospitals accurately reported 90% of newborns having birth defects.

Staff from the BDR conducted site visits and education sessions on the registration process to NJ Early Intervention System providers.

In FY 2009 BDR staff continued to collaborate with staff from the Family Centered Care Program

(FCCP) to develop a case management module for the electronic BDRS. Registry staff held meetings with FCCP staff to determine their needs for a case management component for the new BDRS. During these discussions, a standardized approach to collecting, using, and presenting case-related information was developed.

c. Plan for the Coming Year

In FY-2010, CDC will continue to fund the Program through a cooperative agreement for improvements in the Birth Defects Surveillance System until at least February 1, 2010. Rutgers, the State University -- Bloustein Center for Survey Research will continue the development of the new Birth Defects Registry System (BDRS), which will include a special module for registering children with autism. It is expected that the electronic registration component of the BDRS will begin implementation implementation in several hospitals by July 1, 2009. The remaining hospitals along with the six Autism Centers will be brought "on-line" by January 1, 2010. BCSR will continue its development of the case management component. The beta testing of this component will begin by July 1, 2010 with several Case Management Units. A roll-out of the case management component is expected to begin by end of 2010. The BDRS will improve reporting from hospitals and medical providers as well as improve the information transfer between the Department and the County-based Case Management Units through a secure and HIPAA-compliant Virtual Private Network (VPN).

BDR Staff will provide training to birthing facilities, autism centers, and Case Management Units in the use of the electronic BDRS. The BDR staff also will continue to provide assistance to these entities as they transition from the paper-based system to the electronic system. Staff will continue to monitor the implementation of the electronic BDRS and will assist reporting agencies with concerns.

Audits will again be conducted in each of New Jersey's birthing facilities. Audits will also be conducted in each of the 21 County Case Management Units.

Facilities having the lowest levels of appropriate reporting, based upon results of the hospital audit conducted during FY-2009, will receive remedial assistance from staff of the Birth Defects Registry.

Surveillance activities will expand due to the increase in readily available electronic data. These will include identifying any relationships between diagnoses, geographic and temporal patterns, and other descriptive statistics. BDR staff will continue to work with the reporting agencies to ensure complete and appropriate reporting of mandated diagnoses, especially during the transition from paper forms to electronic registration. BDR staff will continue to work with the Governor's Council on Medical Research and Treatment of Autism and the Autism Centers to understand the epidemiology of autism in New Jersey.

State Performance Measure 7: *Percent of children reported to the NJ Birth Defects Registry by three months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			80	80	80
Annual Indicator	60.2	63.6	59.9	60.7	52.8
Numerator	3421	3385	3703	3649	3037
Denominator	5687	5320	6177	6007	5750

Data Source					NJ Birth Defects Registry
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	80	80

Notes - 2008
Data for 2008 entered as estimate pending verification of completeness of 2008 data file. Final 2008 data will be available in 2010.

Notes - 2007
Data for 2007 entered as estimate pending verification of completeness of 2007 data file. Final 2007 data will be available in 2009.

a. Last Year's Accomplishments
SPM #7 was chosen to measure the timeliness of reporting to the Registry. Because of our link to SCHS Case Management services, though there is no time line for reporting in the legislative rules, the Registry encourages all reporting agencies, but especially birthing facilities, to report children diagnosed with specific congenital birth defects in a timely fashion. Since 2000, the average number of children with congenital defects reported to the Registry by three months of age from all reporting agencies was 59.8 percent. When considering reports only from birthing facilities, the rate increased to 65.4 percent. For registration year 2008, these reporting rates were 52.8 percent and 59.7 percent, respectively. Once reported to the Registry, 70% of the registrations are forwarded to the Case Management Units within 14 days. Registrations are reviewed for duplication (previously registered by another facility), reviewed for completeness and accuracy, coded for diagnosis and geographic location, data entered into the Registry, and a letter sent to the parents/guardians within this time period. 82% of the registrations are processed and forwarded to the Case Management Units within 21 days of registration.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Audits of charts for a three month period on a yearly basis				X
2. Hospital education				X
3. Collaboration with the NJ Hospital Association				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Again this year, staff from BDR visited each of the birthing facilities in New Jersey. In attendance from the facilities included representatives of all pediatric disciplines, nursing, medical records and hospital administration. Included in the presentations by BDR staff were discussions of the importance of registering children as quickly as possible to facilitate the linkage of children with SCHS Case Management Units. Quarterly reports were provided to each birthing facility listing all children registered by their institution. Institutions were instructed to promptly review their quarterly reports and verify that all children diagnosed in their facility for the quarter were properly reported. Staff attended quarterly meetings of the SCHS Case Management Units, and stressed the importance of the registration process.

c. Plan for the Coming Year
Staff will continue to stress the importance of quickly reporting children diagnosed as having birth defects. Facilities with untimely reporting to the Registry will be contacted and reminded of the mandate to report and of the importance of the linkage to SCHS Case Management Units. Quarterly reports and a summary table detailing age at time of registration will continue to be provided. During the annual Birth Defects Reporting audit, birthing facilities having reporting times exceeding three months of age for over 25% of their reported children will receive additional training on the importance of the registration process. Hospital staff will be educated as to their importance in the registration process and how faster reports will enable children and families to more quickly obtain services through the SCHS Case Management Units. The electronic reporting component of the BDRS will facilitate more timely reporting by reporting facilities and reduce duplicate reporting as each facility will be able to review all children previously reported by their facility.

State Performance Measure 8: *The percentage of HIV exposed newborns receiving appropriate antiviral treatment to reduce the perinatal transmission of HIV.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	73	74	75	76	77
Annual Indicator	91.7	82.9	97.0	97.0	97.0
Numerator	176	136	128	128	128
Denominator	192	164	132	132	132
Data Source					Division HIV/AIDS
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	77	78	78	78	79

Notes - 2008
Data for 2008 is not currently available (may be available Fall 2010). Data for 2006 entered as provisional 2008 data.

Notes - 2007
Data for 2007 is not currently available (may be available Fall 2009). Data for 2006 entered as provisional 2007 data.

a. Last Year's Accomplishments
The percentage of HIV exposed newborns receiving appropriate antiviral treatment, was selected to focus efforts on reducing the perinatal transmission of HIV. Please note that the data above has been revised to reflect results from the Survey of Resident Childbearing Women from Division of HIV/AIDS Services, as opposed to previous submissions which have utilized surveillance data from the Division of HIV/AIDS Services.

Early identification and AZT treatment of pregnant women identified as HIV infected appears to be reducing perinatal transmission to newborns. Accurately monitoring the identification and early management of pregnant women and at-risk infants should have a significant impact on reducing the perinatal transmission of HIV. The number of reported cases of HIV/AIDS babies born in NJ dropped from 71 in 1993 to 6 in 2006. Each of NJ's seven Ryan White Title IV Family Centered HIV Care Network Centers has a dedicated perinatal care coordinator responsible for targeting outreach, counseling, testing and long-term follow-up of high-risk adolescents and women of child-bearing age. Pregnant women identified as HIV positive are referred to specialty

clinics within the network. AZT treatment is provided during pregnancy, delivery and to newborns according to the CDC protocol. All newborns are referred and managed within the network. Co-located mother-child or family clinics have been established in each site to facilitate long term maintenance of mother and child in care.

Data from the 2006 Survey of Child Bearing Women (SCBW) indicated that 97% of the mothers/newborns received AZT at the time of labor/delivery. This is a marked increase from 13% in 1994, the first year SCBW specimens were tested for AZT. In conjunction with the Division of HIV/AIDS Services, the Network established a Perinatal HIV Advisory Committee in 2000 to develop a statewide policy for rapid testing and short course therapy to reduce the risk of perinatal HIV transmission in women who present in labor with an unknown HIV serostatus. In 2001 the Standard of Care for Women Who Present in Labor with Unknown HIV Serostatus was developed. The intent of the Standard of Care is to provide HIV counseling and voluntary rapid or expedited testing of mothers in labor or delivery, or newborns in nursery units, if there is no documentation of prior HIV testing. The Standard of Care is currently under review, and may be updated to reflect the new 2006 CDC guidelines for HIV testing.

A hospital policy survey designed to assess the institution's ability to comply with the Standard of Care was implemented in 2005. Of particular note, survey responses indicated that the majority of obstetrical hospitals in the state had policies for documenting HIV status in labor and delivery (L&D). Policies for the provision of HIV counseling and rapid testing in L&D, three quarters of hospitals had point-of-care HIV testing in L&D, and two-thirds of hospitals provided anti-retroviral agents to the mother during labor and to the newborn.

As a result of both targeted intervention to pregnant HIV positive women, and administration of appropriate antiretroviral therapy at birth and in subsequent years, the Network has witnessed an aging trend in its population. The trend table shown below, demonstrates fewer babies born in New Jersey with HIV infection, and a growing HIV+ adolescent population.

In 2007, Bill S2704 was signed into law; requiring health providers to test pregnant women for HIV (Human Immunodeficiency Virus) as part of routine prenatal care unless the woman refused testing. It also requires testing of newborns whose mother's HIV status is either positive or undocumented at the time of delivery. The Ryan White Part D Network sites are already fielding questions from hospitals in regards to the implementation of these new requirements. The Division of HIV/AIDS Services is currently writing the new regulations, and Network staff will participate in providing technical assistance when they are finalized.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing outreach and education targeting pregnant women.		X		
2. Ongoing collaboration with Division of AIDS Prevention and Control.				X
3. Transition education for HIV+ youth.		X		
4. Development of formal medical and social service transition care plans for adolescents approaching adulthood.		X		
5. Ongoing formal Continuous Quality Improvement activities to assess the level of compliance with established health care standards.				X
6.				
7.				

8.				
9.				
10.				

b. Current Activities
The NJDHSS and the seven Ryan White Part D Network are currently engaged in a needs assessment survey. This survey is completed every other year, opposite a Network-wide patient satisfaction survey. The 2009 survey will focus on the educational needs of consumers.

The Network offers an annual retreat for HIV+ women to help them address the loss of loved ones, cope with the grieving process, deal with chronic illness. An additional annual retreat is held for adolescents to provide education on HIV and sexuality. An annual Case Study Day is offered to medical and social service providers of HIV+ clients annually. This year's topic includes the medical and psychosocial needs of gay, lesbian, and transgendered youth.

The annual Quality Improvement study was completed for 2008. In total, 281 charts were reviewed across three age groups, for receipt of medical and social services. Since the inception of a statewide total quality improvement effort in 2001, the pap rate for HIV positive women receiving care at a Network site has increased from 40% to 75%. Another significant change has been the number of children with an undetectable viral load. This number had steadily increased from 26% to 69% in 2008.

c. Plan for the Coming Year
The seven Ryan White Part D Family Centered HIV Care Network Centers in New Jersey will continue in the coming year to target outreach, counseling, testing and long-term follow-up of high risk adolescents and women of child bearing age.

E. Health Status Indicators

Introduction
State MCH program activities have considerable breadth. In order to adequately describe those activities which fall outside the parameters of priority needs and National and State performance measures outlined above, Health Status Indicators are reported separately on the HSI Forms 20 to Forms 21.

Health Status Indicators contribute to your State V agency's ability to assess the MCH needs of the state by providing demographic information on State residents, functioning as evaluative measures, and serving as additional surveillance measures for MCH health. Below are summaries of selected individual Health Status Indicators as they are reported on forms 20 to 21.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.2	8.2	8.5	8.4	8.4
Numerator	9182	9045	9494	9494	9233
Denominator	112117	110697	111727	112715	109539
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source of provisional 2008 data is the 2008 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2008 data will be available in 2010.

Notes - 2007
Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Notes - 2006
Source of 2006 data is the 2006 Electronic Birth Certificate file (as of 5/7/2008).

Narrative:
Health Status Indicator # 01A (Low Birth Weight - the percent of live births weighing less than 2,500 grams) as displayed in the attachment to Section IVB State Priorities (Chart #5) has been very slowly increasing since 1990. Racial disparities persist between white non-Hispanics and black non-Hispanics. Activities addressing this indicator are discussed in sections related to Health Systems Capacity Indicator 05A and State Performance Measure 1.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.9	6.0	6.2	6.2	6.1
Numerator	6307	6333	6574	6624	6402
Denominator	107106	105966	106735	107700	104603
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source of provisional 2008 data is the 2008 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2008 data will be available in 2010.

Notes - 2007
Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Notes - 2006
Source of 2006 data is the 2006 Electronic Birth Certificate file (as of 5/7/2008).

Narrative:
Health Status Indicator # 01B (Low Birth Weight - Singleton Births - the percent of live singleton births weighing less than 2,500 grams) has remained level since 1990. With the effect of the large increase in low-birthweight multiple births removed, HSI #01B has remained level. The racial disparity between white non-Hispanics and black non-Hispanics remains unchanged.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.5	1.6	1.6	1.5	1.6
Numerator	1714	1739	1776	1714	1751
Denominator	112117	110697	111727	112715	109539
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source of provisional 2008 data is the 2008 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2008 data will be available in 2010.

Notes - 2007
Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Notes - 2006
Source of 2006 data is the 2006 Electronic Birth Certificate file (as of 5/7/2008).

Narrative:
Health Status Indicator # 02A (Very Low Birth Weight - the percent of live births weighing less than 1,500 grams) as displayed in the attachment to Section IVB State Priorities (Chart #6) has been very slowly increasing since 1990 like HSI #01A. Racial disparity between white non-Hispanics and black non-Hispanics for HIS #02A is even greater than the racial disparity for HSI # 01A.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.1	1.2	1.1	1.1	1.1
Numerator	1181	1232	1201	1177	1191
Denominator	107106	105966	106735	107700	104603
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the					

last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2008
Source of provisional 2008 data is the 2008 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ. Final 2008 data will be available in 2010.

Notes - 2007
Source of 2007 data is the 2007 Electronic Birth Certificate file (as of 5/6/2009) which includes births in NJ to out-of-state residents and does not include births to NJ residents outside of NJ.

Notes - 2006
Source of 2006 data is the 2006 Electronic Birth Certificate file (as of 5/7/2008).

Narrative:
Health Status Indicator # 02B (Very Low Birth Weight - Singleton Births - the percent of live singleton births weighing less than 1,500 grams) has remained level since 1990. With the effect of the large increase in very low-birthweight multiple births removed, HSI #02B has remained level.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.5	3.7	3.3	3.3	3.3
Numerator	62	65	56	56	56
Denominator	1788012	1737386	1709703	1709703	1709703
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data for 2008 is not yet available from the CDC.
2006 data is provided as a required estimate for 2008. Final 2008 data may be available in Fall 2011.

Notes - 2007
Data for 2007 is not yet available from the CDC.
2006 data is provided as a required estimate for 2007. Final 2007 data may be available in Fall 2010.

Notes - 2006

Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. From the WISQARS website http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html .

Narrative:
Health Status Indicator # 03A (Fatal Unintentional Injuries - the death rate per 100,000 due to unintentional injuries among children aged 14 years and younger) remains the leading cause of death for among children aged 1 to 14 years old. The number per year of specific types of fatal unintentional injuries in New Jersey is small and does not display recent trends.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.6	1.3	1.2	1.2	1.2
Numerator	28	23	21	21	21
Denominator	1788012	1737386	1709703	1709703	1709703
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data for 2008 is not yet available from the CDC.
2006 data is provided as a required estimate for 2008. Final 2008 data may be available in Fall 2011.

Notes - 2007
Data for 2007 is not yet available from the CDC.
2006 data is provided as a required estimate for 2007. Final 2007 data may be available in Fall 2010.

Notes - 2006
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. From the WISQARS website http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html .

Narrative:
Motor vehicle crashes remain the leading cause of death for children 1 to 14 years old. Health Status Indicator # 03B (Fatal Unintentional Injuries - the death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes) does not appear to be decreasing.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	14.8	15.2	16.4	16.4	16.4
Numerator	159	170	185	185	185
Denominator	1074519	1115520	1125137	1125137	1125137
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data for 2008 is not yet available from the CDC.
2006 data is provided as a required estimate for 2008. Final 2008 data may be available in Fall 2011.

Notes - 2007
Data for 2007 is not yet available from the CDC.
2006 data is provided as a required estimate for 2007. Final 2007 data may be available in Fall 2010.

Notes - 2006
Data Source: NCHS Vital Statistics System for numbers of deaths. Bureau of Census for population estimates. From the WISQARS website http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html .

Narrative:
Health Status Indicator # 03C (Fatal Unintentional Injuries - the death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years) may have decreased recently. Motor vehicle crash fatalities remain a leading cause of death for 15 to 24 year olds.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	379.7	186.2	176.5	176.5	176.5
Numerator	6691	3272	3031	3031	3031
Denominator	1762316	1757198	1716883	1716883	1716883
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events					

over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data entered as required estimate for 2008. Final 2008 data may not be available until Fall 2010.

Notes - 2007
2006 data entered as required estimate for 2007. Final 2007 data may not be available until Fall 2009.

Notes - 2006
Source: 2006 Hospital Discharge (UB) records excluding records with BillType = 131 (same day stays). Primary discharge diagnosis 800-995.
Denominator Source: Population Division, US Census Bureau, May 17, 2007.

Narrative:
Health Status Indicator # 04A (Non-fatal Unintentional Injuries - the rate per 100,000 of all nonfatal injuries among children aged 14 years and younger) appears to be decreasing based on the reported data from hospital discharge records.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	35.5	26.9	25.2	25.2	25.2
Numerator	626	473	433	433	433
Denominator	1762316	1757198	1716883	1716883	1716883
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data entered as required provisional estimate for 2007. Final data for 2007 may be available in Fall 2009.

Notes - 2007
2006 data entered as required provisional estimate for 2007. Final data for 2007 may be available in Fall 2009.

Notes - 2006
Source: 2006 Hospital Discharge (UB) records excluding records with BillType = 131 (same day stay/procedures) and deaths. Primary discharge diagnosis 800-995 with an E-code E810-E25.

Narrative:
Health Status Indicator # 04B (Non-fatal Unintentional Injuries - the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger) appears to be decreasing based on the reported data from hospital discharge records.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	179.9	141.3	116.6	121.4	121.4
Numerator	1857	1543	1325	1325	1325
Denominator	1032251	1091626	1136404	1091626	1091626
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data entered as required provisional estimate for 2008. Final data for 2008 may be available in Fall 2010.

Notes - 2007
Provisional 2006 data entered as required 2007 estimate. Final data for 2007 may be available in Fall 2009.

Notes - 2006
Source: 2006 Hospital Discharge (UB) records excluding records with BillType = 131 (same day stay/procedures) and deaths. Primary discharge diagnosis 800-995 with an E-code E810-E25.

Narrative:
Health Status Indicator # 04C (Non-fatal Unintentional Injuries - the rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years) does not display a clear trend based on recent hospital discharge data.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	21.3	23.0	24.4	24.4	24.4
Numerator	6102	6595	7031	7031	7031
Denominator	286813	286813	287937	287937	287937
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2006 data entered as estimate for 2008. Final data for 2008 may be available in Fall 2010.

Notes - 2007
2006 Data entered as estimate for 2007. Final data for 2007 may be available in Fall 2009.

Notes - 2006
Source: Sexually Transmitted Disease Program in the NJDHSS
Denominator - Population Division, US Census Bureau, May 17, 2007.

Narrative:
Health Status Indicator # 05A (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia) is based on data from the Sexually Transmitted Disease Program in the DHSS. The increase in HSI #05A and HSI #05B may represent an increase in the reporting of cases to the DHSS, and increase in the screening for cases or a true increase in the incidence of cases.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.0	7.8	8.2	8.2	8.2
Numerator	10544	11801	12387	12387	12387
Denominator	1507367	1507367	1507367	1507367	1507367
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data from 2006 entered as a provisional estimate for 2008. Final data for 2008 may be available in Fall 2010.

Notes - 2007
Data from 2006 entered as a provisional estimate for 2007. Final data for 2007 may be available in Fall 2009.

Notes - 2006

Source: Sexually Transmitted Disease Program in the NJDHSS
Used 2004 Population denominator from CDC WISQARS website.

Narrative:
Health Status Indicator # 05B (Sexually Transmitted Disease (Chlamydia) - the rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia) is based on data from the Sexually Transmitted Disease Program in the DHSS. The increase in HSI #05A and HSI #05B may represent an increase in the reporting of cases to the DHSS, and increase in the screening for cases or a true increase in the incidence of cases.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	107869	76902	18934	170	8972	67	2824	0
Children 1 through 4	451182	323250	78689	775	36664	292	11512	0
Children 5 through 9	560214	406195	93822	1859	43681	429	14228	0
Children 10 through 14	597675	436343	103107	2198	42970	518	12539	0
Children 15 through 19	593501	438639	104701	2191	36998	588	10384	0
Children 20 through 24	542903	400491	96178	2396	34128	685	9025	0
Children 0 through 24	2853344	2081820	495431	9589	203413	2579	60512	0

Notes - 2010

Narrative:
An overview of demographic trends including HSI #06A & B (Demographics -Total Population) and HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	82782	25087	0

Children 1 through 4	349985	101197	0
Children 5 through 9	454275	105939	0
Children 10 through 14	494050	103625	0
Children 15 through 19	492372	101129	0
Children 20 through 24	433262	109641	0
Children 0 through 24	2306726	546618	0

Notes - 2010

Narrative:
An overview of demographic trends including HSI #06A & B (Demographics -Total Population) and HSI #07A & B (Demographics -Total live births) are provided in section III. A. State Overview. The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	104	49	52	0	0	0	0	3
Women 15 through 17	2184	1134	894	0	19	0	0	137
Women 18 through 19	4955	2867	1804	0	40	0	0	244
Women 20 through 34	80408	54817	13877	0	8064	0	0	3650
Women 35 or older	24076	18305	2942	0	2108	0	0	721
Women of all ages	111727	77172	19569	0	10231	0	0	4755

Notes - 2010

Narrative:
An overview of demographic trends including HSI #07A (Demographics - Live births to women (of all ages) enumerated by maternal age and race.) is provided in section III. A. State Overview. The growing diversity of New Jersey's mothers raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse backgrounds. The gradual increase in average age of mothers and first time mothers continues similar to national trends. More data and trends in maternal age are available at the New Jersey Department of Health and Senior Services' State Health Assessment Data (NJSHAD) System. This site provides statistical numerical data as well as contextual information on the health status of New Jerseyans and the state of New Jersey's health care system.
http://10.17.120.52:8080/ibisph-view-1.8.0.0/indicator/view/MaternalAge.AgePie.html

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	55	49	0
Women 15 through 17	1140	1044	0
Women 18 through 19	2727	2221	0
Women 20 through 34	58584	21710	0
Women 35 or older	20192	3865	0
Women of all ages	82698	28889	0

Notes - 2010

Narrative:
Births to mothers of Hispanic ethnicty continue to increase (26.4% of all births in 2007, See Chart #1 Births by Race/Ethnicity). The growing diversity of New Jersey's maternal and child population raises the importance of addressing disparities in health outcomes and improving services to individuals with diverse ethnic backgrounds.

More data and trends in maternal age and Hispanic ethnicity are available at the New Jersey Department of Health and Senior Services' State Health Assessment Data (NJSHAD) System. This site provides statistical numerical data as well as contextual information on the health status of New Jerseyans and the state of New Jersey's health care system.
http://10.17.120.52:8080/ibisph-view-1.8.0.0/indicator/view/MaternalAge.AgePie.html

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	548	292	202	2	36	5	8	3
Children 1 through 4	76	45	15	1	4	4	4	3
Children 5 through 9	61	38	13	0	3	3	3	1
Children 10 through 14	71	35	30	0	2	2	2	0
Children 15 through 19	263	167	67	0	8	8	12	1
Children 20 through 24	446	262	118	3	20	20	20	3
Children 0	1465	839	445	6	73	42	49	11

through 24								

Notes - 2010

Narrative:
Efforts to reduce deaths among children (Health Status Indicator 08A) are discussed in detail in sections related to National Performance Measure #10 (motor vehicle deaths), National Performance Measure #16 (suicide deaths), State Performance Measure #2 (community-based Fetal and Infant Mortality Review Teams), Health System Capacity Indicator #05A and #05B (Percent of low birth weight and infant deaths).

Death rates decreased for all age groups in New Jersey over the past decade. For residents under the age of 15, death rates declined by one-fifth or more. The 15-24 age group experienced the smallest decline (5%). For every age group, death rates were higher for males than for females. The greatest difference was in the 15-24 year age group.

Infant mortality rates decreased among most races/ethnicities between 1994 and 2005, yet the rate among Black mothers remained more than twice the rate for any other race/ethnicity (See Chart #7 Infant Mortality by Race/Etnicity). Short gestation/low birth weight and congenital anomalies have been the two leading causes of infant death since at least 1999. In 2004, more than one-third of infant deaths were attributed to those two causes. SIDS, which had been the third leading cause in 2000-2003, declined to seventh in 2004. Maternal complications of pregnancy, respiratory distress, and bacterial sepsis were the third through fifth leading causes, respectively.

The leading causes of death of residents aged 1-4 years in 2004 were unintentional injuries (22 deaths) and congenital anomalies (12 deaths). These two causes accounted for one-third of deaths in the age group.

Among residents 5-14 years old, the leading causes of death remained unintentional injuries (37 deaths) and cancer (21 deaths). Over 40% of the deaths in this age group were due to those two causes. More than 60% of the deaths due to unintentional injuries were motor vehicle-related.

In 2004, the leading causes of death among residents aged 15-24 years were unintentional injuries (282 deaths), homicide (130), suicide (78), cancer (57), and heart disease (26). More than half of the deaths due to unintentional injury were motor-vehicle related. While death rates for the other four leading causes displayed no clear trend from 1994-2004, the suicide rate among 15-24 year olds had been declining fairly steadily from 1995 through 2002 before taking an upturn in 2003 that continued in 2004.

For more data and trends in pediatric deaths see the NJ Center for Health Statistics website at http://nj.gov/health/chs/stats04/mortality.shtml.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	445	95	0
Children 1 through 4	52	20	0
Children 5 through 9	55	2	0

Children 10 through 14	65	10	0
Children 15 through 19	221	29	0
Children 20 through 24	372	50	0
Children 0 through 24	1210	206	0

Notes - 2010

Narrative:
Efforts to reduce deaths among children (Health Status Indicator 08B) of all ethnicities are discussed in detail in sections related to National Performance Measure #10 (motor vehicle deaths), National Performance Measure #16 (suicide deaths), State Performance Measure #2 (community-based Fetal and Infant Mortality Review Teams), Health System Capacity Indicator #05A and #05B (Percent of low birth weight and infant deaths).

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	2230115	1626689	437981	6785	158660	0	0	0	2004
Percent in household headed by single parent	26.0	0.0	0.0	0.0	0.0	0.0	0.0	26.0	2004
Percent in TANF (Grant) families	100.0	13.3	58.6	0.1	0.8	0.0	0.0	0.0	2004
Number enrolled in Medicaid	578892	259995	307264	2105	9528	0	0	0	2004
Number enrolled in SCHIP	97400	0	0	0	0	0	0	97400	2004
Number living in foster home care	7893	1736	5130	0	0	0	0	1027	2004
Number enrolled in food stamp program	157187	24739	80562	134	1693	0	0	50059	2004
Number enrolled in WIC	177798	0	0	0	0	0	0	177798	2006
Rate (per 100,000) of juvenile crime arrests	2631.0	2018.0	6013.0	707.0	0.0	0.0	0.0	362.0	2004
Percentage	11.0	0.0	0.0	0.0	0.0	0.0	0.0	5.0	2006

of high school drop-outs (grade 9 through 12)									

Notes - 2010

Narrative:
Efforts to address the various issues and indicators included in Health Status Indicator 09A (Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race) are discussed in other specific sections.

For 'Number enrolled in Medicaid ' see X in Section Y.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	1828694	401421	0	2004
Percent in household headed by single parent	0.0	0.0	26.0	2004
Percent in TANF (Grant) families	0.0	0.0	100.0	2004
Number enrolled in Medicaid	0	0	279006	2004
Number enrolled in SCHIP	0	0	97400	2004
Number living in foster home care	0	0	7893	2004
Number enrolled in food stamp program	0	0	50059	2004
Number enrolled in WIC	76459	80542	0	2006
Rate (per 100,000) of juvenile crime arrests	2639.0	2502.0	0.0	2004
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	5.0	2006

Notes - 2010

Narrative:
Efforts to address the various issues and indicators included in Health Status Indicator 09A (Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race) are discussed in other specific sections of the MCH Block Grant Application/Annual Report.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	2288504
Living in urban areas	2288504
Living in rural areas	0

Living in frontier areas	0
Total - all children 0 through 19	2288504

Notes - 2010
Source: Population Division, US Census Bureau, May 1, 2008.
NJ has no rural or frontier designated areas.

Narrative:
As a very densely populated urban state, the distribution of children living in New Jersey has not changed much over the past decade. New Jersey does not have any rural or frontier designated areas. The population of children in New Jersey has been fairly stable. The location of large MCH populations in New Jersey's urban centers has supported the focus of MCH services on the Health Mothers Health Babies Communities as described in Section III. B. 1. (Preventive and Primary Care for Pregnant Women, Mothers and Infants) and State Priority #4 (Increasing Healthy Births).

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	8685920.0
Percent Below: 50% of poverty	4.2
100% of poverty	8.7
200% of poverty	22.8

Notes - 2010
Source: Population Division, US Census Bureau, May 1, 2008.

Estimate based on Census 2000.

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.
http://www.census.gov/hhes/www/macro/032008/pov/new46_100125_01.htm
Table - POV46: Poverty Status by State: 2007

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.
http://www.census.gov/hhes/www/macro/032008/pov/new46_185200_01.htm
Table - POV46: Poverty Status by State: 2007

Narrative:
Economic indicators such as Health Status Indicator #11 (Percent of the State population at various levels of the federal poverty level) have a strong impact on the health of a state's communities. The impact of the ecomonic downturn has yet to be seen on the poverty status and measures of access to health services of New Jersey residents. Efforts to assure access to quality health care services for New Jersey's MCH populations are described in sections on National Performance Measure #14 (The percent of children with special health care needs whose families have adequate private and/or public insurance to pay for the services they need.), National Performance Measure #13 (Percent of children without health insurance), and National

Performance Measure #18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester).

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2288504.0
Percent Below: 50% of poverty	5.0
100% of poverty	10.7
200% of poverty	28.2

Notes - 2010
Source: Population Division, US Census Bureau, May 1, 2008.

Source: Kids Count
http://www.kidscount.org/datacenter/

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.
http://www.census.gov/hhes/www/macro/032008/pov/new46_100125_03.htm
POV46: Poverty Status by State: 2007
Below 100% and 125% of Poverty -- People Under 18 Years of Age

County Level 2006 Poverty Data available at
http://datacenter.kidscount.org/data/bystate/Rankings.aspx?state=NJ&ind=2150

Source: U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement.
http://www.census.gov/hhes/www/macro/032008/pov/new46_185200_03.htm
POV46: Poverty Status by State: 2007
Below 185% and 200% of Poverty -- People Under 18 Years of Age

Narrative:
Economic indicators such as Health Status Indicator #12 (Percent of the state population aged 0 through 19 years at various levels of the federal poverty level) have a strong impact on the health of a state's children. The impact of the ecomonic downturn has yet to be seen on the poverty status of children and measures of access to health services for the children of New Jersey. Efforts to assure access to quality health care services for New Jersey's children are described in sections on National Performance Measure #4 (The percent of children with special health care needs whose families have adequate private and/or public insurance to pay for the services they need.), National Performance Measure #7 (age appropriate immunizations), National Performance Measure #9 (Percent of third grade children who have received protective sealants), and National Performance Measure #13 (Percent of children without health insurance).

F. Other Program Activities

The Reproductive and Perinatal Health Services monitors the grant with the Family Health Line that is a component of the Center for Family Services, Inc. The program coordinates quarterly staff trainings for the agency with an emphasis on current family health initiatives. The trainings covered the Federally Qualified Health Center (FQHC) Project, The Governor's Mammography Campaign, the Lead Screening Initiative, Diabetes Prevention and Prematurity/Folic Acid topics. The Reproductive and Perinatal Health Services provides the Family Health Line with consultation, technical assistance and educational material support to facilitate its participation in community events and networking.
During the grant Year 2006-07, the Family Health Line received and assisted 12,372 calls, and made 13,763 referrals.
/2010/ During the 2008 calendar year , the Family Health Line received and assisted 15,173 calls.//2010//

G. Technical Assistance

The technical assistance needs of the State are reported on Form 15 and will likely be updated after submission of the MCH Block Grant Annual Report/Application.

V. Budget Narrative

A. Expenditures

Annual expenditures are summarized in below. The State Title V Programs Budget and Expenditures by Types of Service, parallels the MCH pyramid which organizes MCH Services hierarchically from direct health care services through infrastructure building services.

B. Budget

/2010/ New Jersey has maintained and increased commitment of State funding support for maternal and child health activities. Since 1989, maintenance of effort has included State appropriations for children with special health care needs and support for population based outreach and education for pregnant women and their infants to name a few.

State appropriations support a number of maternal and child health programs. In the State fiscal year 2010 budget most programs and services are maintained at the SFY 2009 levels. Due to the continuing state fiscal crisis, the proposed SFY 2010 budget includes reductions in a few service areas including family planning, postpartum depression education, cleft lip and palate, Tourettes Syndrome and early intervention . However, based on the critical nature of the budget deficit in the state the proposed budget demonstrates an ongoing commitment on the part of the State to support to the best of its ability services to the most vulnerable populations. Since the State budget will not be finalized until June 30, 2009, the following are the proposed funding levels for programs and services for FFY 2010 that reach maternal and child health populations in New Jersey:

Birth Defects Registry	***$ 564,000***
Cleft lip and palate projects	***$ 693,000***
Family Planning Services	***$ 7,590,000***
Infant mortality reduction including a new project focused on reduction of black infant mortality	***$ 2,500,000***
Sudden Infant Death Syndrome	***$ 221,000***
Newborn screening (revenue)	***$ 3,306,000***
Postpartum Depression education	***$ 2,000,000***
Postpartum Depression screening and referral	***$ 2,000,000***
Early intervention for developmental delay/disabilities	***$ 97,299,000***
Childhood lead poisoning prevention	***$ 987,000***
Hemophilia services	***$ 1,245,000***
Catastrophic illness in children relief fund	***$ 1,606,877***
Handicapped children's fund, which is used to support subspecialty care and case management services	***$ 2,516,000***
Fetal Alcohol Syndrome	***$ 570,000***
MCH Services	***$ 6,113,000***
Council Physical Fitness and Sports	***$ 50,000***
Tourettes Syndrome	***$ 950,000***
Autism Registry	***$ 500,000***
Governor's Council on Autism Research	***$ 500,000***

All of the funding sources are considered in the programmatic narrative portion of this application. There have been few variations in the allocation and expenditure of the federal/state partnership funds for maternal and child health over the last few years. This year state appropriations do not include cost of living increases. New Jersey has undertaken several new or expanded initiatives over the past few years, which may in some cases, result in slight variations in allocations or expenditures. //2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.